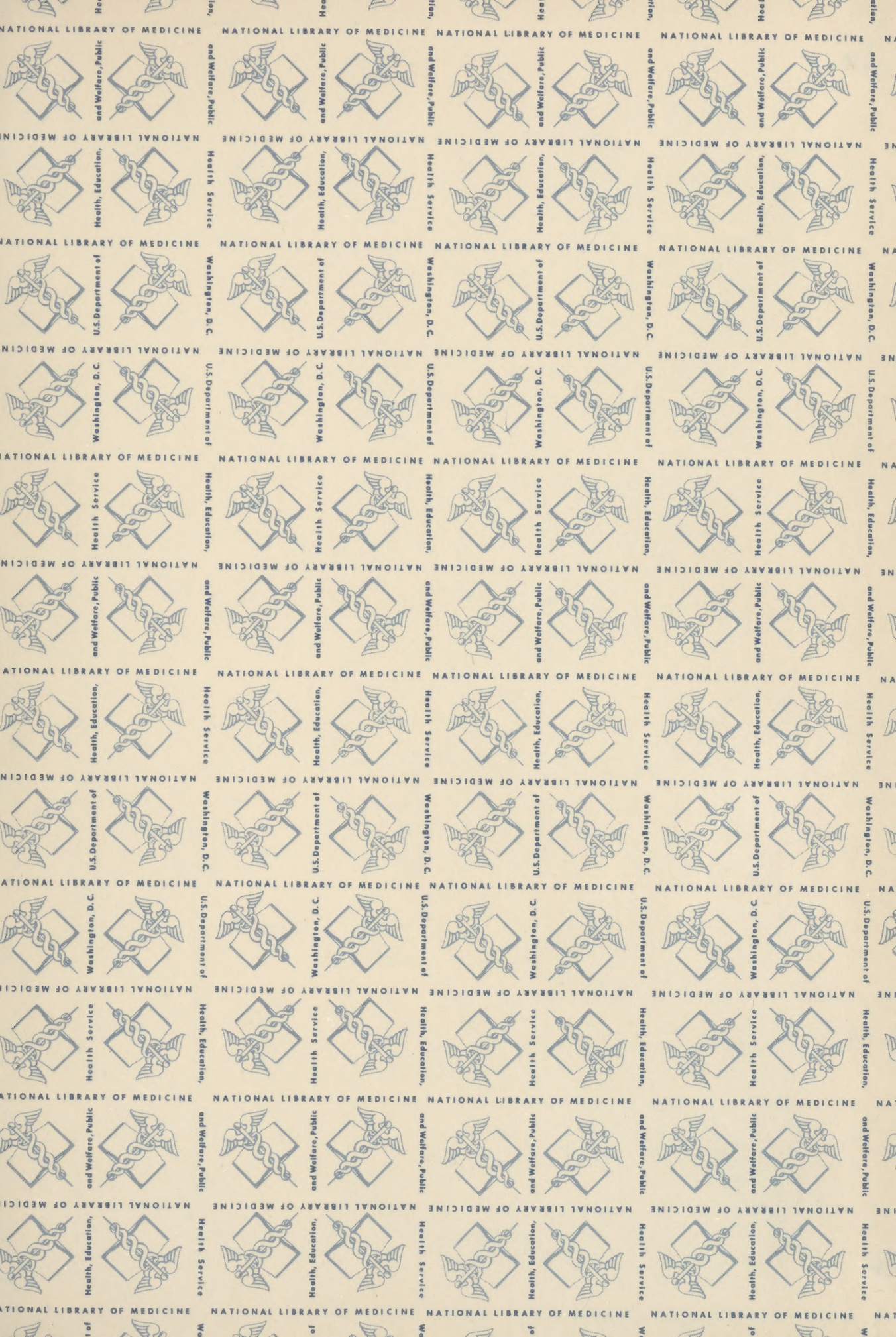

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Hemorrhoids
Acute Pericarditis
History of Otology
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VOLUME 58 JANUARY 1962 NUMBER 1

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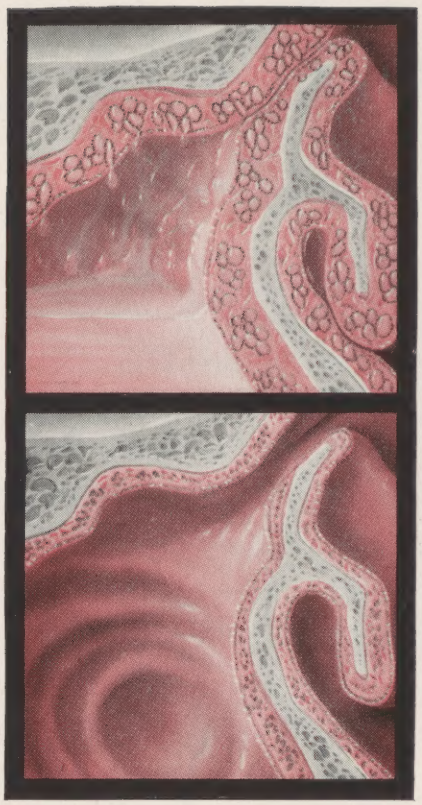
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CONTENTS

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ORIGINAL ARTICLES

Exsanguinating Mariscae (Hemorrhoids)—*Leon Banov, Jr., M. D. and H. Biemann Othersen, Jr., M. D.* ---- 1

Observations of an Occupational Program in an Industrial Plant of about Five Hundred Employees—*Joseph L. Goodman, M. D.* ---- 4

Pulmonary Infiltration Eosinophilia—A Case Report—*Belton D. Caughman, M. D. and J. R. Paul, Jr., M. D.* ---- 6

History of Otology—*Richard W. Hanckel, M. D.* ---- 11

MEDICAL COLLEGE CLINICS

Electrocardiogram of the Month—Acute Non-Specific Pericarditis—*Dale Groom, M. D.* ---- 17

EDITORIALS

Voluntary Agencies ---- 20

A Blow to Chiropractic ---- 20

More Nurses Available ---- 21

What's the Price of Medicine? ---- 21

Watch Your Words ---- 21

FEATURES

President's Page ---- 19

Medical Television ---- 22

News ---- 25, 30

Civil Defense ---- 29

Deaths ---- 31

Public Relations ---- 32

Fifty Years a Doctor—J. L. Anderson, M. D. ---- 35

Could You Afford to Retire?—Donald G. Kilgore, M. D. ---- 36

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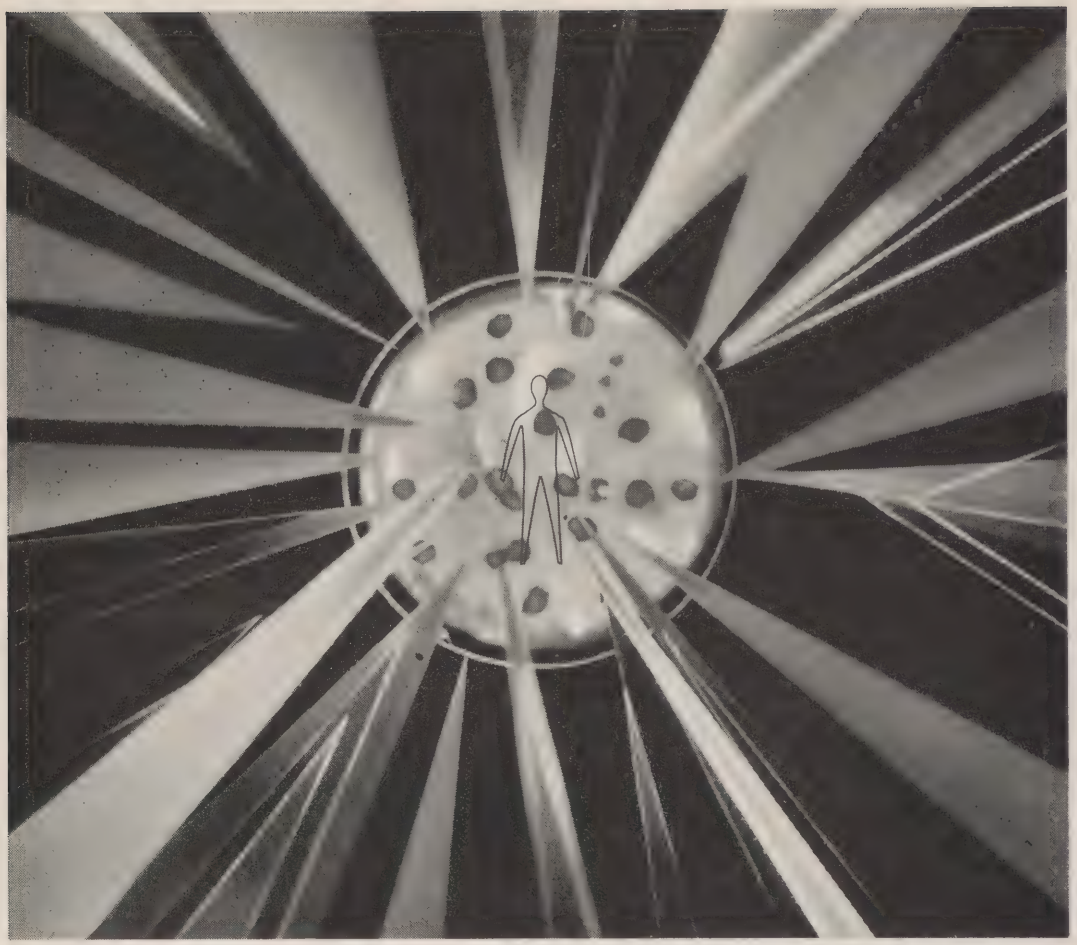
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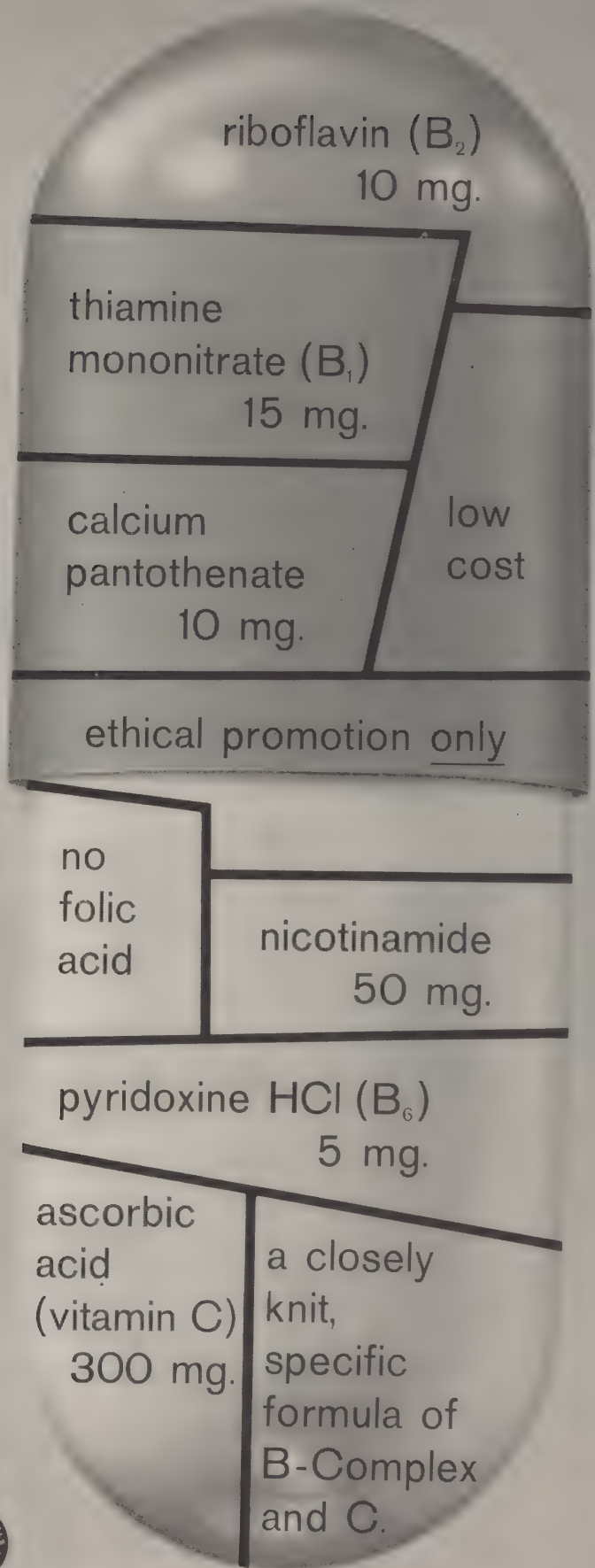


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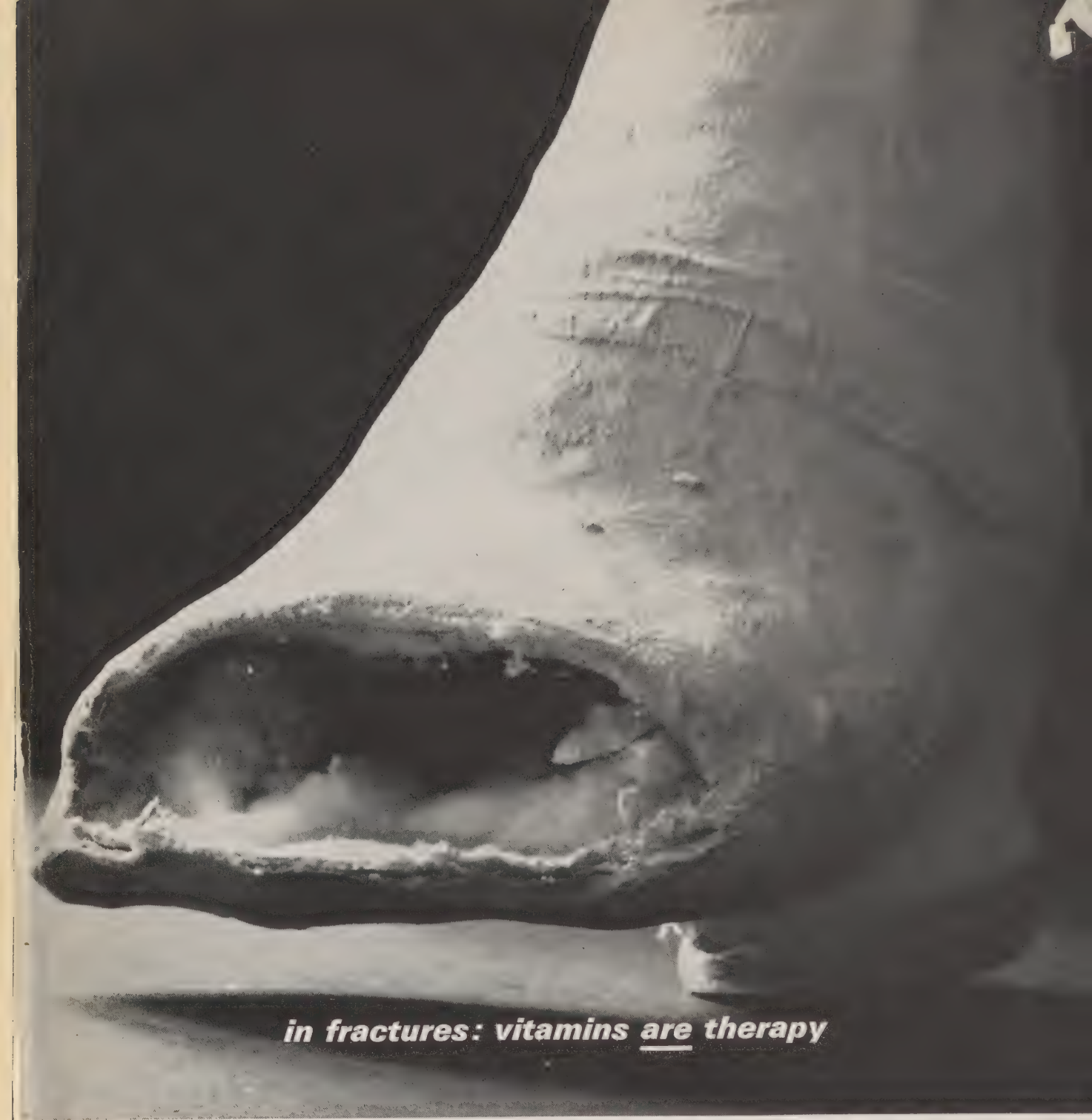
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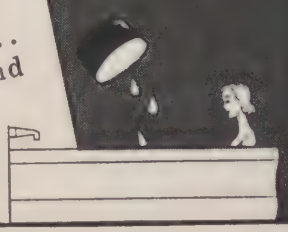
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VOLUME 58 January, 1962 NUMBER 1

EXSANGUINATING MARISCAE (HEMORRHOIDS)

LEON BANOV, JR., M. D.* AND
H. BIEMANN OTHERSEN, JR., M. D.**

From the Department of Surgery, Medical College of South Carolina, Charleston, S. C.

Bleeding mariscae can produce not only troublesome anemia but occasionally actual exsanguination. The purpose of this paper is to emphasize that fact and to present several illustrative cases in which the hemorrhage from mariscae (hemorrhoids) became life-threatening.

"Hemorrhoids" should be defined and classified. Hemorrhoids are vascular tumors composed of one or more infected segments of the hemorrhoidal plexus of veins and are usually classified as external or internal. Internal hemorrhoids are located superior to, and the external hemorrhoids, inferior to the pectinate line, that "water shed" line which demarcates the anus from the rectum. External hemorrhoids are covered with stratified squamous epithelium of ectodermal origin, and accordingly have a somatic nerve supply and are capable of producing pain. Internal hemorrhoids, on the other hand, are overlaid with rectal mucosa, of endodermal origin, and, therefore, are more prone to bleeding and less likely to be painful.

In addition to producing blood loss, hemorrhoids can cause pain, protrusion, and repeated episodes of thrombosis. Oftentimes, they are associated with pruritus ani and constipation.

Usually, the bleeding from hemorrhoids appears gradually, and the patient is often unable to recall the exact time of onset. Moreover, he is indefinite as to the quantity of blood passed. Some estimate of the amount of blood loss can be made by questions regarding the frequency of bleeding and the amount of staining of the tissue paper and the commode water. Occasionally when bleeding occurs daily and deeply colors the commode water, a profound anemia can develop within a few weeks. Some patients carefully scrutinize their feces while others are completely oblivious of excreta and may minimize anorectal blood loss.

While it is true that about 95 per cent of the cases of rectal bleeding are due to hemorrhoids, a thorough and methodical examination

*Assistant Professor of Surgery, Medical College of South Carolina.
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must be carried out to exclude other gastrointestinal blood loss before therapy is initiated. Adenomas (polyps) and cancer are two serious causes of rectal bleeding, and their presence must be excluded.

Visual inspection of the anus, performed first, may reveal external hemorrhoids. Next a digital examination is done with the patient's buttocks well-retracted. Internal hemorrhoids, if present, are usually not palpable. Proctoscopy with an anoscope and then with a sigmoidoscope may reveal the presence above the pectinate line of easily visible bluish bulges representing internal hemorrhoids. A point of bleeding may or may not be seen. There is no correlation between the size of hemorrhoids and their bleeding potential. External hemorrhoids, covered by tough stratified squamous epithelium, usually do not bleed.

Often the proctosigmoidoscopic examination can be performed on the patient's initial visit with bowel preparation accomplished in the office with a disposable enema of the phosphate solution type. As a final step every patient with rectal bleeding should have a double contrast x-ray examination of the colon to rule out lesions above the reach of the sigmoidoscope.

Occasionally, after digital, proctosigmoidoscopic, and x-ray examinations, the cause of the bleeding can not be found. However, since rectal bleeding occurs with defecation, a maneuver to evoke straining may provoke the bleeding site. This maneuver is accomplished in two ways. With the anoscope in place, the patient is requested to strain slowly. Bulging is noted and sometimes the bleeding site of the internal hemorrhoids is seen. As an alternate procedure, the patient is sent to the toilet to strain, to turn about in a squatting position, and to hold the cheeks of the buttocks apart. The female patient is appropriately draped. With the buttocks retracted, straining causes bulging of the external hemorrhoids, protrusion of the internal hemorrhoids and redundant mucosa, and sometimes bleeding. This maneuver to demonstrate internal hemorrhoids is not new. Nearly seven hundred years ago Theodoric of Lucca wrote " . . . instruct the patient to sit down and strain until they issue from the anus and appear".[1] These procedures are an essential part of any anorectal examination since hemorrhoids usually do not bleed when the patient is recumbent and relaxed.

The following cases are chosen to show the occasional severity of hemorrhoidal blood loss.

Case Summaries

Case 1. This 42 year old white man consulted his family doctor for rectal bleeding presumably due to hemorrhoids. The man appeared pale and anemic and hemoglobin was 7.75 grams, or 52%; red blood count, 2.7 million; and white cell count, 9,550. He was referred to the senior author for treatment.

On examination, the patient reported that his hemorrhoids, known to be present for some time, had troubled him recently. Ten days prior to his initial visit, "a stream of blood was passed". Subsequently, his bleeding increased, reddening the commode water with every defecation. Further, with passage of most stools, he was aware of an anorectal protrusion which required manual replacement. Only once in a while did he have anorectal pain, and then, very little.

On regional examination, there were moderate external hemorrhoids in the right anterior, right posterior, and left lateral positions. The internal hemorrhoidal components were associated with considerable redundant rectal mucosa. Proctosigmoidoscopy was not remarkable.

On admission to the hospital, his hemoglobin was approximately 7 grams and the red blood count was 2.41 million.

Before operation, he was given 2500 ml. of blood to raise his hemoglobin to 10.5 grams and red blood count to 3.86. Three days after admission hemorrhoidectomy by the ligature-excision open technique under spinal anesthesia was carried out. He withstood the procedure very well. Immediately after operation, another transfusion of 500 ml. was given.

He had a satisfactory convalescence and on discharge from the hospital hemoglobin was 13 grams and red cell count, 4.2 million. His anorectal wound healed very well and his recovery was uneventful.

Case 2. This 33 year old white man consulted his physician for increasing lassitude of about two weeks duration. Hemoglobin at that time was 7.0 grams. He gave a vague history of gastro-intestinal distress but denied tarry stools. He did, however, have hemorrhoids with frequent bouts of bleeding. Proctosigmoidoscopy and x-ray examinations were not remarkable.

He was placed in the hospital and received 2,000 ml. of whole blood. He improved and went home.

This patient was first seen one week after his discharge from the hospital. He stated that he had had rectal bleeding of five years duration. However, in the preceding two months his bleeding had increased, sufficient to redden the commode water. With defecation, he felt a protrusion which required manual replacement.

On regional examination, there were anal folds of external hemorrhoids. The internal hemorrhoids were of large size and were associated with a large amount of redundant rectal mucosa. With straining, there was protrusion of the internal hemorrhoids completely encircling the anal orifice.

He was again hospitalized and under saddle-block anesthesia a plastic amputative-type hemorrhoidectomy was carried out. This was a more radical operation since there was an extensive removal of the large prolapsing mucosa and the vein bearing tissues on both lateral aspects of the anorectum. He had a satisfactory and uneventful convalescence. His wound healed very well and he had no further rectal bleeding.

Case 3. This 30 year old Negro man was admitted to Roper Hospital on October 29, 1957, with a history of easy fatigability and exertional dyspnea. He complained of spots before his eyes and dizziness on walking a half block. The onset of coryza and a productive cough prompted his quest for medical care and his hospital admission.

He told of having passed bright red blood mixed with his stools for 4 to 5 months prior to admission. He denied hemorrhoids and had noted dark tarry stools on 2 to 3 occasions. He had no ulcer symptoms. No history of worms and no exposure to toxins was elicited. He had noted a 15 pound weight loss over a period of two months prior to admission.

Physical examination showed the patient to be well developed, apparently well nourished, and having very pale mucous membranes. There was a systolic cardiac murmur. A small umbilical hernia was easily reducible. Digital rectal examination produced light brown feces and no hemorrhoids. The initial impression was that of a severe anemia of unknown etiology.

Pertinent laboratory data were as follows: Hemoglobin 3.2 grams; RBC 1.3 million; packed cell volume 12%; WBC 5,900; stool examination 2 plus benzidine reaction.

The following tests were negative: bone marrow study showed only normoblastic hyperplasia; Coomb's test; Rumpel-Leede's test; red cell fragility.

The impression of the staff after laboratory studies was that there was a severe hypochromic, normocytic anemia with the site of blood loss unknown.

Proctosigmoidoscopy to 25 cm. revealed an unprepared bowel. A second such examination was not remarkable except for a "few bleeding hemorrhoids".

X-ray studies of the entire gastro-intestinal tract were negative. Stool examinations showed no parasites or ova.

The hemoglobin on November 8, fell to 2.5 grams. Fifteen days after admission and after exhaustive tests, it was decided that rectal bleeding might be due to internal hemorrhoids. Two days later with the passage of a watery stool, prolapse of a rosette of hemorrhoids established the diagnosis.

Surgical consultation was obtained. A total of 3,500 ml. of blood was given. Three large blood clots were surgically removed from the prolapsed tissues. Soaks were applied and the patient received chloramphenicol 250 mg. every 6 hours for 5 days before operation. On November 20, nearly one month after admission, a plastic amputative-type hemorrhoidectomy was carried out under spinal anesthesia.

The post-operative course was satisfactory and uneventful and the patient was discharged from the hospital one week after operation. On discharge, his hemoglobin was 13 grams and volume packed cells, 44%. There was no further bleeding.

Summary

Mariscae, a dignified term for the familiar undignified hemorrhoids or piles, should be considered as a frequent cause of rectal bleeding. Hemorrhoidal bleeding can be a serious threat to life as illustrated in 3 case summaries. The size of the hemorrhoids does not necessarily reflect their ability to bleed. To demonstrate prolapsing internal hemorrhoids and, sometimes, to find the hemorrhoidal bleeding areas, the old diagnostic procedure of requesting the patient to strain has been found to be useful. Requesting the patient to strain in order to demonstrate bleeding from internal hemorrhoids should become a fundamental diagnostic procedure which every physician can easily employ. Even with obvious hemorrhoids, thorough examination including proctosigmoidoscopy, and double contrast x-ray studies should be employed to rule out other sites of gastro-intestinal hemorrhage.

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OBSERVATIONS OF AN OCCUPATIONAL PROGRAM IN AN INDUSTRIAL PLANT OF ABOUT FIVE HUNDRED EMPLOYEES

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The author discusses the benefits to be produced by industrial medicine, and cites particularly the effects in a plant of 500 employees He describes specifically the results of a routine search for diabetes which yielded 44 cases.

The years have brought about many changes in occupational medicine. Industrial medicine is a sub-specialty gradually becoming full time with compensations comparable to the private practice of clinical medicine. Occupational medicine has been submerged because it was long regarded as a refuge for the incompetent and insecure physician. Today, the industrial physician must be well versed in medico-legal matters, modern methods of diagnosis, and latest toxicology.

Once industrial medicine was limited to the treatment of on-the-job injuries. The view now is to encompass the concept of preventive medicine as well as the treatment of related industrial diseases. Industrial physicians now have to pursue the overall purpose of medical care for the whole patient, rather than treatment of on-the-job physical trauma.

There are many aspects of an industrial program, such as preventive medicine, industrial diseases and injuries, and non-occupational injuries and diseases. The completeness of the program must encompass these three. The treatment of industrial disease and occupational injuries is self-explanatory and is not covered in this paper. We are concerned here primarily with an illustration of what can be done in a small plant in a preventive aspect.

It becomes apparent that in order to sustain production, the health of the employee and the maintenance of this health is as important as the maintenance of the equipment with which he works. Therefore, in this paper we have outlined the following program.

1. We do pre-employment physical examinations on all new employees.
2. We do yearly examinations on all employees.
3. Employees who are in a hazardous industrial job, are examined every six months.

In the course of those examinations we provide immunizations, yearly chest x-ray examination, yearly electrocardiograms, and auditory examinations. A routine examination consists of a complete history, complete physical, blood examination, and post-prandial blood sugar. Also, a complete urinalysis, hemoglobin reading, electrocardiogram, and orthorator examination to see if any visual disturbance which may affect the performance of the applicant is present. Results of these examinations are made known to the applicant or employee and a letter is forwarded to his family physician.

An interesting survey was conducted at the Transportation Depot in Charleston, South Carolina as part of the yearly examination to determine the presence of diabetes mellitus. In this survey we used the post-prandial blood sugar using the Folin Wu method. As our determining value we took 150 to 160 mg. per 100/ml as the out limits of normal. Five hundred and thirty-one blood sugar tests were reported. In this group of 531 persons who were between the ages of 19 and 65 and working actively each day, we found 44 diabetics.

Nineteen of these people needed immediate medical care. Twenty-five mild diabetics were maintained on diets alone. A discussion of the post-prandial blood sugars shows that of the 44 diabetics discovered in the survey, 25 of them would have been missed with a fasting blood sugar determination, and the 19 severe diabetics would certainly have been discovered. It is apparent to this examiner that the post-prandial blood sugar is infinitely superior to the fasting blood sugar as a means of survey. It is also of interest to show that every year for the past six years, we have found an active tuberculous patient, and have in the past year found one with an active carcinoma of the lungs. A comprehensive industrial program is rewarding in its result in economic savings to industries through controlled health and increasing efficiency, a marked decrease in the employee absenteeism, and the undying gratitude of the patient for your efforts in discovering a hidden disease.

An occupational health program should be a broad comprehensive, constructive approach to the problems of industrial plants through medical supervision of the worker and his health problems. Justification for these services is reflected in their accomplishments, as prevention is not only better than a cure, but is less expensive. Prevention is the keystone of the industrial health program.



Bookplate of Thomas Smith Denny, M. D. of Charleston. Late Eighteenth Century

PULMONARY INFILTRATION EOSINOPHILIA

A CASE REPORT

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As early as 1923[4] case reports of hypereosinophilia appeared in the medical literature. Symptomatology has varied from the mild and transitory[1] to the acute and fulminating, to chronicity, and to fatalities.[2-8] Terminology applied to the syndromes has varied as widely. Eponyms of past and present usage are listed in Table 1.

TABLE 1.
EPONYMS OF P. I. E.

Allergic pneumonia
Eosinophilic pneumonopathy syndrome
Eosinophilic asthma
Tropical eosinophilia
Weingarten's syndrome
Pseudotuberculosis of lungs
Eosinophilic pneumonia
Allergic pulmonary infiltration
Pulmonary ascariasis
Eosinophilic lung
Pulmonary eosinophileosis
Eosinophilia with spleenomegaly
Scande eosinophilic sanguinaire
Familial eosinophilia
Benign eosinophil leukemia
Idiopathic hypereosinophilia
Loeffler's syndrome

Loeffler[9] in 1932 and 1936 described several cases characterized by eosinophilia, transient pulmonary infiltration and a rather benign clinical course of two to three weeks duration with malaise, cough and low grade fever. Sixty percent were afebrile. Since Loeffler's original description, other cases manifest by dypsnea, asthmatic-like wheezing, hemoptysis, fever, weakness, and weight loss with eosinophilia and pulmonary infiltrations have been reported.

Bass, Coutinho, Hall, Kariks, Danaraj,[10-14] and others have described numerous cases of tropical eosinophilia having a geographical distribution confined for the most part to the area of the 23rd degree parallel. The disease has an insidious onset of one to four weeks, then shows sudden fever, respiratory distress, malaise, anorexia, and paroxysms of coughing and night sweating. The acute phase is followed by a chronic or prolonged convalescence. As in Loeffler's syndrome, there is an associated eosinophilia and pulmonary infiltrate but of less transient nature than that observed in the former. Whether the two diseases are identical and vary only in the degree of severity remains in dispute. They are now being reported under the general term of pulmonary infiltration eosinophilia, abbreviated P. I. E. Eosinophilia comparable in degree to that seen in P. I. E., and due to similar granulomatous lesions associated with hepatic visceral larva migrans, having a prolonged asymptomatic course is well known.

The pathogenesis of Loeffler's syndrome or P. I. E. as in the present case is usually obscure. Many agents, intrinsic and extrinsic have been incriminated. Tschuny[15] reported a case of pulmonary infiltration with eosinophilia in a fireman following smoke inhalation. Thirteen percent of Mark's[16] cases revealed parasitic infestations. Ascaris,[17-20] mites, W. Bancrofti[18] and visceral larvae migrans[29, 30] are only a few of many parasites associated with the syndrome. Experiments have demonstrated that a perifocal reaction with transitory shadows on the x-ray film occur during the migration of the larvae of ascaris through the

lungs.[19, 20] Causal relationship between parasitic infestation and P. I. E., remains indistinct. Drugs, bacteria, viruses and fungi[7, 21-23] have also been incriminated. Table 2 gives a fairly comprehensive coverage of the various factors categorically arranged into the three recognized groups.

TABLE 2.

KNOWN ETIOLOGY	
Parasites	
Ascaris	Necator americanus
A. Braziliense	Visceral larva migrans
W. Bancrofti	Ancylostoma duodenale
Trichinella spiralis	Strongyloides
Trichuris trichiura	E. vermicularis
Amoebae	Microfilariae
S. Mansoni	Fasciola hepatica
P. Westermani	
Fungi	
Histoplasmosis	Unicariasis
Coccidiodomycosis	
Bacteria	
Viruses	
Mites	
Neoplasms	
HYPERSENSITIVE	
Loeffler's	Tuberculin sensitivity
Bronchial asthma	Periarteris nodosa
Drugs (PAS-pen.)	Collagen diseases
Pollens	(unspecified)
Smoke inhalation	
DRUG RESPONSIVE	
Tropical eosinophilia	

The pathophysiological basis is probably one of an immume hypersensitivity reaction, the shock organ being the interstitial tissue of the lung in contradistinction to the bronchial system as in asthma. Other allergic phenomena, hay fever, asthma, urticaria, vascular rhinitis and eczema, have been described in association with P. I. E.[24] The pathological findings appear to depend on the severity and duration of the disease process. Pulmonary biopsies have been done in several cases. Christofordis[5] reported eosinophilic infiltrations of the lobular septa and of the perivascular adventitia with a histological picture of organizing foci of exudation and fibrotic nodules. Operative specimens of Buckles and Lawless revealed fibrosis and an eosinophilic infiltration with evidence of a vasculitis. These findings are similar to those found at autopsy by Bayley.[26] Eosinophilic infiltrations have been noted in lymph nodes, spleen, liver and in the bone marrow. The early changes are essentially those of an infiltrative process with eosinophiles and the formation of granulomatous lesions followed by resolution. In the more severe cases, the process persists with eventual fibrosis and involvement of the vascular system with a necrotizing arteritis and phlebitis.

Complications vary from a capillary-alveolar block syndrome[7] with emphysema due to diffuse, predominantly ball-valve obstruction of alveolar ducts, to endocarditis with congestive heart failure. The cardiac changes are not unlike those of endocardial sclerosis except both ventricles and septum are involved. Mural thrombi have been noted in all cases reviewed.[8, 27] Severe liver damage has been noted particularly in cases having a marked eosinophilia.[5] Dexter[29] noted an unusual psychotic reaction in three patients. The onset and subsidance of the eosinophilia coincided with that of the psychotic episode. The mechanism was felt to be a systemic intoxication; however, one could speculate that CNS infiltration with eosinophilia or vasculitis was the cause. Other complications may arise but for the most part are rare. Purpura, encephalitis and ulcerative colitis have been described. Eosinophilic leukemia has frequently been erroneously diagnosed in patients with visceral larva migrans and P. I. E. The bone marrow in these cases characteristically shows an intense eosinophilia with development of these cells as of all other elements of normal marrow in an orderly fashion, but with ratios of eosinophiles to all other elements increased to 3 or 4 up to 10 or more. Differentiation from leukemia can be confidently made in such cases as there is no preponderance of blasts or promyelocytes but rather of mature forms, and also there is no crowding out of other forms. Absolute numbers of polymorphonuclear cells and platelets in peripheral blood are not diminished.

A correlation has been postulated between the level of eosinophilia and the onset of resolution of the pneumonic process with resolution beginning immediately following

the eosinophilic peak.[16] Others have found no such relationship.[5] The tropical type of eosinophilia has been reported to show a more permanent response to arsenicals and Hetrazan, although some observers have not been impressed.[14] When this occurs it must be due to the elimination of the cause rather than symptomatic relief or temporary suppression of the allergic reaction. Temporary remission following steroids has been reported.[8] Antihistamines have not been reported to be beneficial. They had been used in our patient without effect on the swelling and pain (urticaria) in the right foot.

Symptomatic therapy of associated allergic phenomena may be indicated for wheezing or urticaria. Elimination of the causative agent is advisable if intestinal parasites are demonstrated. Exploration has demonstrated visceral larvae in granulomatous lesions in the liver, but such exploration is not necessary, as such visceral larvae cannot be completely removed, and since they disappear after an asymptomatic course of several months without treatment.[30] Whether every patient with the syndrome in areas of high incidence of endemic parasites should receive anti-parasitic drugs is questionable. If the drug can be given without hazard to the patient, there is probably no good reason for withholding it.

Case Report

W. C., a five year old white female, was apparently in good health until July 1960, at which time she received rather severe injuries in an automobile accident requiring approximately eight days hospitalization. She was in a coma for the first 48 hours due to cerebral concussion. There was no apparent neurologic residual damage. The patient had no further difficulty until mid-August. Intermittent fever with temperature elevations to 102 degrees F. were noted over a period of three weeks. The child had associated episodes of nausea, vomiting, anorexia and malaise. On occasions, she complained of pain in the right upper quadrant on awakening in the mornings with relief after eating. The mother noted the right foot to be swollen on one or two occasions and the child complained occasionally of pain in foot. She was felt by her family physician to have an infection and was treated, but without improvement. Several blood counts revealed marked leukocytosis with 70 to 80 percent eosinophiles. The child was referred to the Medical Center on date of admission for further evaluation.

The child was born spontaneously at term weighing 8 lb. 2 oz. No postnatal difficulties were noted. Growth and development were within normal limits. She was artificially fed and received supplemental vitamins and the usual routine immunizations. She has had uncomplicated measles and chicken pox. She has not been in a hospital except as noted in the present illness. She has not had allergic symptoms or other serious illnesses.

Family history was non-contributory. There was no history of allergic phenomenon or parasitic infestation in the other members of the family.

The child was a well developed, well nourished white female in no distress. She was alert and cooperative. The temperature was 98.8 degrees and the pulse rate was 108 per minute. There were several abrasions on the lower extremities with crusting. Eyes, ears, nose and throat were negative. No lymphadenopathy was noted. The lungs were clear. A grade one systolic murmur was noted in the pulmonic area which was felt to be functional. The liver was palpable just below the right costal margin. The remainder of the examination including complete neurological examination was within normal limits.

Laboratory data were as follows: Hb. 12.3 gms., WBC 37,200, lymphs 18%, polys 3%, eosinophiles 78%, and basophiles 1%. RBC 4.2 million, VPC 35, MCV 85, MCH 29, MCHC 35%, Vol. index 0.98, reticulocyte count 0.6%, platelet count 252,000. Stools were negative for blood, ova and parasites on several occasions. The urine was negative. Tuberculin skin test was negative at 72 hours.

Bone marrow aspiration was performed. The smears were quite cellular. Megakaryocytes were normal in appearance and abundant. Erythropoiesis and granulopoiesis were normal with no evidence of an arrest in development; however, in the myeloid series, a marked eosinophilia was noted in all stages of development. The peripheral smear showed a preponderance of eosinophiles and several large, pale lymphocytes. The platelets were adequate, and the red cells slightly hypochromic with some anisocytosis.

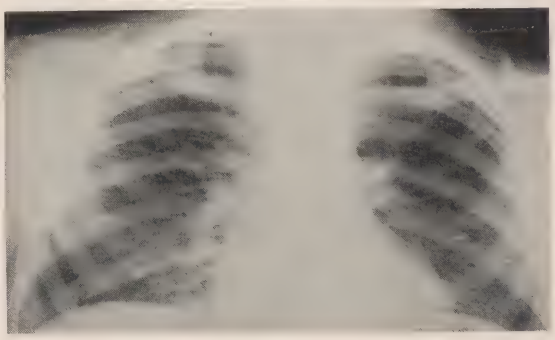


Figure 1
Chest film on admission. (see text)

Chest x-ray film, Figure 1, showed accentuation of the bronchovascular marking with minute miliary nodules throughout both lung fields. The heart, diaphragm, and bones of the thorax were negative. The

absence of rales or other respiratory findings in the face of these striking x-ray findings has amazed all concerned.

The clinical course was unremarkable. There was only a slight elevation of the temperature on one occasion to 99.6 degrees. After several days observation the patient was discharged. Follow-up after two months without symptoms revealed persistence of eosinophilia and moderate clearing of miliary lesions on x-ray examination.

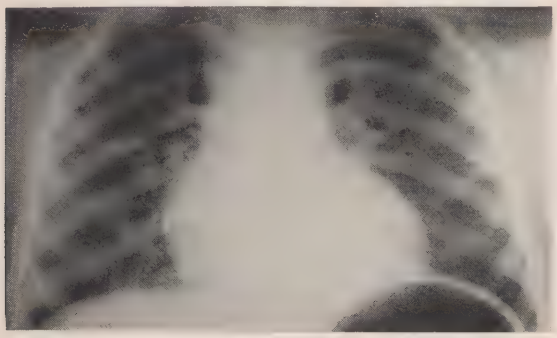


Figure 2

Chest film two months after admission — moderate clearing.

Discussion

It would appear that the radiological changes as well as the clinical course of P. I. E. are inconstant and therefore these cases must be managed on an individual basis. The infiltration may be minimal, involving one or both lungs without segmental or lobular distribution or diffuse, homogenous and irregular patterns. Pleural effusions may also occur. The duration of eosinophilia may vary from a few days to several weeks or months.

It has been said that the differential diagnosis of P. I. E. is not complete without prime consideration of tuberculosis. There was no indication of an active or inactive tuberculosis process in this patient. Polyarteritis nodosa, Hodgkin's disease, unspecified collagen diseases, lymphomas and various pneumonias of bacterial, viral or fungoid origin should be considered. We do not believe there is sufficient evidence of these to indicate further specific studies.

No specific therapy was felt indicated in view of the patient's complete asymptomatic state with absence of cough or dyspnea despite the radiological changes. Periodic x-ray films and close observation, however, have been recommended. Prompt institution of steroid therapy has also been suggested to the referring physicians if acute pulmonary symptoms that do not respond promptly to symptomatic medication should occur. Steroids, either in the form of ATCH, cortisone or a derivative, appear to be the treatment of choice for severe episodes with dramatic clinical improvement and a return of the eosinophilia to normal levels.[5, 16] Use of steroids may have to be continued for considerable periods or several courses in symptomatic cases.

Summary

A case is reported of P. I. E. which appears to fit the original description of Loeffler's syndrome.

Review of the literature with classification of clinical patterns and categorical listing of agents known or suspected to be significant in initiating the disease has been presented.

The pathophysiology appears to be one of a hypersensitivity reaction with an eosinophilic infiltration of the lungs which may be transitory. Complications and occasional fatalities have been recorded in the literature.

Dramatic clinical improvement of acute symptoms is reported to result with the use of steroids; however, recurrences or relapses have been noted. Therapy, when indicated, should be continued over a period of several months and withdrawal should be gradual.

Symptomatic treatment of co-existing allergic phenomenon should be instituted as clinically indicated.

Further experimental investigation into the etiology and pathogenesis is needed before the cause or causes are known.

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Neurological manifestations in cervical spondylosis —O. R. Talbert and H. S. Pettit (Charleston). South M J 54:1093-1100, *Oct.* 61.

Cervical spondylosis is that series of changes in the cervical vertebrae, their ligaments and intervertebral discs generally attributed to aging. Congenital anomalies or external trauma may speed the "aging" process. Neurological complications of these degenerative changes may result from (a) compression of cervical nerve roots, (b) compression of the spinal cord, and (c) impairment of blood flow through the vertebral arteries. Radiographic changes in the cervical spine alone are not reliable in diagnosing these complications. In comparing radiographs of the cervical spine in a group of asymptomatic controls and a group of patients with one or more of these neurological complications there was found no significant difference between the two groups. Careful clinical evaluation and cervical myelography are necessary to establish the diagnosis.

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HISTORY OF OTOLOGY

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History is regarded by some as a dull parade of facts, by others as a spirited distillate of rumor, but by this Medical History Club I am sure it is viewed in its true perspective, that is, that we are beneficiaries of an historical insurance policy which allows us to profit from past events. For whether it be fact or fiction, it is necessary to have some knowledge of the past in order to speak authoritatively on our present day concepts. This paper makes no attempt to separate fact from fiction. It simply recounts the story as it is written and hopes that it will crystallize for you some of the problems which have presented themselves, both those that have been solved and those that remain unsolved.

The story of otology, as with other branches of medicine, begins with Hippocrates; it flourished briefly, settled into the complacency of the fourteen-hundred-year Dark Age era and had its Renaissance when Man began again to exercise his mental processes. It is even now undergoing a second Renaissance.

Fortunately, man's ignorance has been matched by his interest in his body and his curiosity about how the various parts of it work. In order to understand the physiology of a part of the body, one must first understand its structure.

Hippocrates (460-377 B. C.) was the first to take witchcraft out of medicine by introducing the scientific approach in solving some of our problems in anatomy. In the field of otology, he was the first to describe the tympanic membrane which he stated looked like a thin-spun web and was a part of the organ of hearing. Hippocrates was aware that tonsillitis might be followed by otitis. It was recognized at that time that brain abscess was sometimes related to otitis, but it was thought that the otitis was secondary to the brain abscess. This misconception persisted for many centuries.



HIPPOCRATES

The "adenoid state" was described; the patient had a pointed face, aural discharge, cephalalgia, high and narrow palate and an irregular arrangement of teeth.

Aural therapy was limited to the promotion of external drainage and the instillation of oily compounds. Contused ears from physical combat were frequently seen.

Celsus (25 B. C. - 50 A. D.) advocated that the skin be carefully sutured. If the skin is unbroken, but a swelling occurs, it was recommended that an incision be made behind the ear and a window cut in the cartilage.

Tinnitus was recognized as being associated with colds in the head, headache or general disease.

Insects were removed from the canals by using wool soaked in resin. Other foreign bodies were removed by irrigation and with

Read before the Robert Wilson Medical History Club of Charleston, May 4, 1961.

blunt hooks or probes. Sneezing was encouraged as a means of eliminating them. In another method the patient was laid with his ear on a plank and the latter was struck with a mallet.

Galen (130-200 A. D.) added little to our knowledge of otology. However, he did note that if caries of the meatus existed, an incision should be made behind the ear and the carious bone scraped. Guthrie states that this is the earliest record of the mastoid operation.

After fourteen hundred years of the Dark Ages, we find that an obscure Niccole of Venice in 1494 employed a special type of silver or iron tube as a hearing aid.

Andreas Vesalius (1514-64) described two of the ossicles, the malleus and the incus, but missed the stapes. Ingrassia (1510-1580) thought the stapes was two ossicles and described the head, neck and crura as one and the footplate as another. It was finally well described by Eustachius (1520-74). Eustachius also described the cochlea and was the first to recognize the tensor tympani muscle. The auditory tube which bears his name had been previously observed.

Fallopius (1523-1562) described the semicircular canals and discovered the chorda tympani nerve. The bony fallopian canal which encloses the facial nerve is named for him, but had previously been described by Galen.

In the early 17th century Casserio, Filio, and Rivinus came up with some fairly accurate descriptions of the anatomy of the middle and inner ear. Rivinus described the notch in the bony tympanic ring which bears his name. He thought that the notch served as a communication between the middle and external ear. Later it was demonstrated that the lateral wall of the tympanic cavity is imperforate.

Duverny (1648-1730) was the author of the most popular book on otology of the time. He accurately described the passage of the auditory nerve to the cochlea. He was aware of the existence of the membranous labyrinth. He had observed the communication between the middle ear and mastoid cells. He did not know the origin or distribution of the chorda tympani.

Knowledge of the physiology of hearing in this period was not far advanced. It was thought that the ear contained certain inborn air which served as a resonator for the movements of the tympanic membrane. It was not clear whether the inner ear contained air or fluid. That the cochlea or some part of it was essential to hearing was known because it was recognized that a certain amount of hearing was possible even though the drum and ossicles were destroyed and the tympanum contained pus. The function of the semicircular canals was not known.

Clinical otology was not advanced far beyond its ancient position. Futile attempts at replacement of a ruptured tympanic membrane with an artificial one were made. Deafness and mutism were recognized as being coexistent, but no reasonable explanation had been offered. Several schools for deaf mutes had been established, one by Ponce de Leon (1520-1584) who taught pupils to write the name of objects pointed out to them. Also Jerome Cardan (1501-1576), an eminent mathematician, devised a system of raised letters and also a sign system to teach communication to the deaf mute.

In the early 18th century Valsalva and Cassebohm were the two aural anatomists of note. Among other structures described were the membranous labyrinth and the auditory nerve. The stapedius muscle was recognized. The stapes was still described as two bones, the head being called the "os orbiculare".

In the second half of the 18th century Meckel and Cotugno made important contributions. The latter discovered that the labyrinth contained fluid, and that the perilymph communicated with the subarachnoid fluid via the cochlea aqueduct.

By the last quarter of the 18th century the gross anatomy of the ear was described essentially as it is today. The knowledge of physiology was faulty. By the end of the 18th century, however, the wave theory of the transmission of sound was described by Rotheram and he fairly accurately described sound reception by the ear.

Clinical otology improved somewhat in the 18th century. Valsalva advocated evacuating

pus from the middle ear by performing "Valsalva's experiment".

Edme-Gittles Guyot, a layman, described the use of the eustachian catheter in 1724. Cleland used this procedure in 1741 and added to it suction via a close fitting tube in the external auditory canal to improve hearing.

Eli, an itinerant Parisian ear surgeon, employed myringotomy as early as 1720.

Morgani in 1736 corrected the Hippocratic impression and demonstrated that brain abscess was secondary to middle ear infection.

Also, in 1736 Jeon-Louis Petit adapted the process of trephining to include the infected mastoid cavity and so devised the simple mastoidectomy procedure. An account of this was not published until after his death in 1774. Lawrence Turnbull of Philadelphia was the first to perform this operation in America in 1862. In England it was first done by James Hinton in 1868.

A school for the deaf-mute was founded in Paris in 1755 by Abbé Charles-Michel de Eppé. By 1799 many schools for instructing deaf-mutes were established throughout Europe.

In the 19th century Scarpa was a prominent aural anatomist. He used the fetal labyrinth because of the ease of dissection. He described the saccule and utricle. The perilymph and endolymph had already been described. Corti in 1851 published the first description of the precise termination of the eighth nerve. Also in 1851 Reissner described the vestibular membrane. Deiters, Held, and Von Monakow did considerable work in the central connections of the eighth nerve.

Local differences in the drum membrane were observed by Henry Jones Shrapnell in 1832. Francois Kibes, Jr. studied the membrane covering the round window and found that it contained an outer one continuous with the inner lining of the tympanum, an inner one continuous with the lining of the cochlea, and a peculiar middle one.

Some authors of this period still spoke of four ossicles and some still mentioned two extra muscles, the laxator tympani, major and minor.

In the 19th century some physical characteristics of sound were discovered. For instance, it was found that the velocity of sound in a gas was independent of pressure or density provided the temperature was constant. Also, Savart in 1830 demonstrated that intensity depended upon the amplitude of vibrations and not upon their frequency. Noise was thought to differ from sound because of the inability of the human ear to distinguish the element of vibration in noise. However, Fourier in 1822 showed that any repetitive disturbance could be represented by the summation of a number of simple harmonic forms. Incidentally at the present time Aram Glorig defines noise as any unwanted sound. Octave relationships were found to be due to doubling (or halving) of the frequency. That sound and light behave similarly was known and it had been demonstrated that the law of reflection (the angle of incidence equals the angle of reflection) applied to sound as well as light.

Knowledge of physiology in this century lagged considerably behind anatomy and physics. Weber in 1835 supposed that the cochlea dealt with bone conduction and the vestibule and semicircular canals with air-borne sounds. Savart (1791-1841), however, later demonstrated conclusively that sound is transmitted directly to the tympanic membrane by air and not first to the bones of the skull and then to the tympanic membrane as had been previously thought.

The eustachian tube, once thought to be for the conduction of sound to the ear, was demonstrated by Jean Itard to be the means of equalizing the pressure on the two sides of the drum.

Flourens was the first to demonstrate the vestibular function of the eighth nerve.

During the latter half of the 19th century Helmholtz became the supreme authority in the physiology of audition as well as vision. He demonstrated the movements of the ossicles by attaching a kymograph lever to the incus or stapes. He concluded that vibrations of the perilymph produced vibrations to the basilar membrane, but exactly how the hair cells were stimulated by these motions was not clear. Both Corti and Hensen did pioneer work on the inner ear as is indicated by the naming of certain structures there.

Helmholtz gave the range of hearing as from 30 to 16,000 cycles per second, with certain exceptional individuals being able to hear up to 38,000 cycles. It was found that one could differentiate with the ear as distinct sounds, stimuli as rapid as 100 per second whereas, in the eye stimuli at only 10 per second resulted in fusion.

Further work with the vestibular function using pigeons was done in the last quarter of the 19th century by Glotz, Cyon, and Brown. However, even at this late date it was thought that vertigo could be produced after section of both eighth nerves.

Clinical otology, lacking a firm physiologic background, progressed very little during the 19th century. During the first half several good textbooks appeared, among them William Wilde's and Joseph Toynbee's. Thomas Buchanan described an artificially illuminated instrument somewhat like an otoscope. Helmholtz suggested the use of the ophthalmoscope to examine ears. A combination of these two instruments was eventually achieved and represents our modern otoscope. Emil Siegle in 1864 introduced the pneumatic otoscope.

In the second half of this century several atlases of the tympanic membrane, reflecting the growing use of the otoscope, were published. Among them was one by Adam Politzer.

Certain congenital malformations of the external ear and canal were recognized. Other conditions and diseases were exotoses of the canal and eczema, otomycosis, polyps and hematoma. In the middle ear acute and chronic otitis were known as well as polyps. Obstruction of the eustachian tube was frequently found to be due to enlarged pharyngeal tonsillar tissue. Catheterization and inflation of the tube was advocated by Itard. Politzer advised forcing air into the nostrils at the moment that the patient swallowed. Politzer demonstrated that the so-called "dry catarrh" of the middle ear was in most cases otosclerosis.

Very little was known of inner ear disease. It was known that trauma and middle ear disease could involve the inner ear and produce deafness. Also deafness of luetic origin was known. Hutchinson published a description of congenital lues consisting of a triad of symptoms, notched incisors, interstitial keratitis, and labyrinthine disease. Prosper Meniere described recurrent sudden vertigo and hearing loss, but the hydropic dilatation of the membranes of the inner ear was not recognized until recently. Robert Barany of Vienna differentiated labyrinthine vertigo from other varieties.

Many tests were devised during the 19th century, among them those to differentiate conductive from nerve deafness. Rinne and Weber developed the two tests which bear their names.

Mastoid surgery which had its beginning with Petit in 1736 was adopted by Herman Schwartze and improved by Emmanuel Zaufal in 1884.

Kessel in 1878, Boucheron in 1888 and Miott in 1890 were the three who performed mobilization of the stapes in deafness due to otosclerosis in the 19th century. Their approach was via a myringotomy opening. The operation was opposed by Siebenmann and Politzer and was soon abruptly abandoned in spite of some rather encouraging reports, especially by Miott. Blake and Jack in America in the early 1890's practiced extraction of the stapes, but that was not followed up.

This then was the situation at the beginning of the 20th century. Mastoid surgery for infections was coming into its own, reconstructive surgery for deafness had gone into a decline. For although the first fenestration operation was reported in 1897 by Passow, he did not follow up this line of attack and very little was attempted by others until Holmgren in 1916 began his long series of operations for otosclerosis which covered a thirty year period. In 1923 he introduced the operating microscope. In 1924 Sourdille on a visit to Holmgren received his inspiration and returned to Paris to develop his multistage fenestration operation. He reported his work in America in 1937 at the New York Academy of Medicine. Lempert heard his paper and proceeded to develop a one-stage fenestration operation.

In 1938 Lempert reported 18 successes in 23 operations. He and his pupils improved the original technic so that today there has emerged a fenestration procedure which comes



GUNNAR HOLMGREN

Born September 27, 1875.
Died September 6, 1954.
Pioneer in fenestration surgery, the first to use the binocular operating microscope, founder of the Acta oto-laryngologica.



MAURICE SOURDILLE

Born October 25, 1885.
His ingenious tympanolabyrinthopexy permanently restored useful hearing for the first time in cases of otosclerosis and formed the basis for the one-stage fenestration operation of Lempert.

very close to the final solution of the problem of osteogenic closure.

In 1952 Rosen, apparently unaware of the work of Miott, began to palpate the stapes to determine the degree of fixation preliminary to fenestration. In one case the stapes was accidently mobilized with remarkable immediate hearing improvement which continued for several years. In 1953 Rosen described purposeful mobilization of the stapes employing the transmeatal approach employed by Lempert for tympanosympathectomy.

Mobilization was adopted and modified by many ear surgeons and today we have the stapedectomy procedure with vein graft and polyethylene strut advocated by Shea and Schuknecht's modification using fat from the ear lobe tied in place with wire to replace the stapes. This surgery is still in the process of modification and development and it is impossible to predict how far it will replace fenestration as the preferred surgical treatment for fixation.

It is fortunate for otology that Lempert's



JULIUS LEMPERT

Born 1890.
Foremost advocate of the endaural approach to the temporal bone. His one-stage fenestration operation led to the renaissance of reconstructive surgery for conductive hearing losses.



HORST WULLSTEIN

Born June 24, 1906.
Eminent otologic surgeon who developed the concepts and technics of tympanoplasty.

operation revived interest in ear surgery, because chemotherapeutic and antibiotic agents were making their appearance and were eliminating the necessity for surgery in the treatment of acute middle ear and mastoid infections.

Rehabilitation surgery for deafness due to chronic middle ear and mastoid disease has been pioneered by Wullstein and Zollner of Germany. The former first described tympanoplasty in 1953. Since this beginning Wullstein and others have improved and developed the technic. Among the most notable of these improvements has been the development of the pedicle flap to line the mastoid cavity. It was described by R. A. Charland of Montreal in the December 1960 *Laryngoscope*.

These three operative procedures, the fenestration by Lempert, mobilization of the stapes by Rosen, and tympanoplasty by Wullstein, have triggered a tremendous amount of interest in the anatomy, physiology, and pathology of the ear so that we are now in the midst of a second Renaissance in otology. Among our unsolved problems is the cause of otosclerosis on which we are doing research work at this time.

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Who Speaks for Health

Everybody and his brother, it seems, has become an authority on health—expounding a best way to treat, a best way to keep well, a best way to pay for it all. In voices which will become louder in the months ahead:

—Some labor leaders who never had to decide how to handle a child's serious illness are demanding assembly-line medical programs.

—Some institutional administrators who never have fathomed a distraught mother's pulse are promoting central full-salaried medical staffs as the only good source for patient care.

—Some Congressmen who could not tell a placebo from a peccadillo are trying to dictate prescribing practices and to legislate research incentive, while others would impose a costly health care system on certain people who neither need it nor want it.

These self-styled medical experts are not merely suggesting or clarifying; they intend to diagnose, treat and prognosticate illness. They embrace the concept that the patient shall acclimate to the process, rather than vice versa—that a do-it-yourself technology of "average medicine" can be formulated. They refuse to recognize that health progress is a dynamic thing which must be fought for and shored up and exported by a constancy of enterprise which corresponds to the battle for freedom itself.

Contrast this with the enlightened ones in government, labor, business and health who seek out those medical, technological and economic advances which may serve the physician in his practice. Theirs is the role of urging him to weigh merits—of a prepayment mechanism, of a biomedical engineering technique, of a newer and safer drug. He is the captain, they know; only he can and should decide. Unfortunately, however, too many practicing physicians tend to equate clinical skill with ideological understanding—and have been struck dumb with complacency. Their voices are needed as never before.

No government bureau or legislative committee, no labor group, no industry can ever speak adequately for an individual's health. Nor, in a specific sense, can any health organization. Who, then? Your physician, guarding your total well-being. He can speak eloquently and effectively for your health—if he will but insist on being heard.

Medicine At Work

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

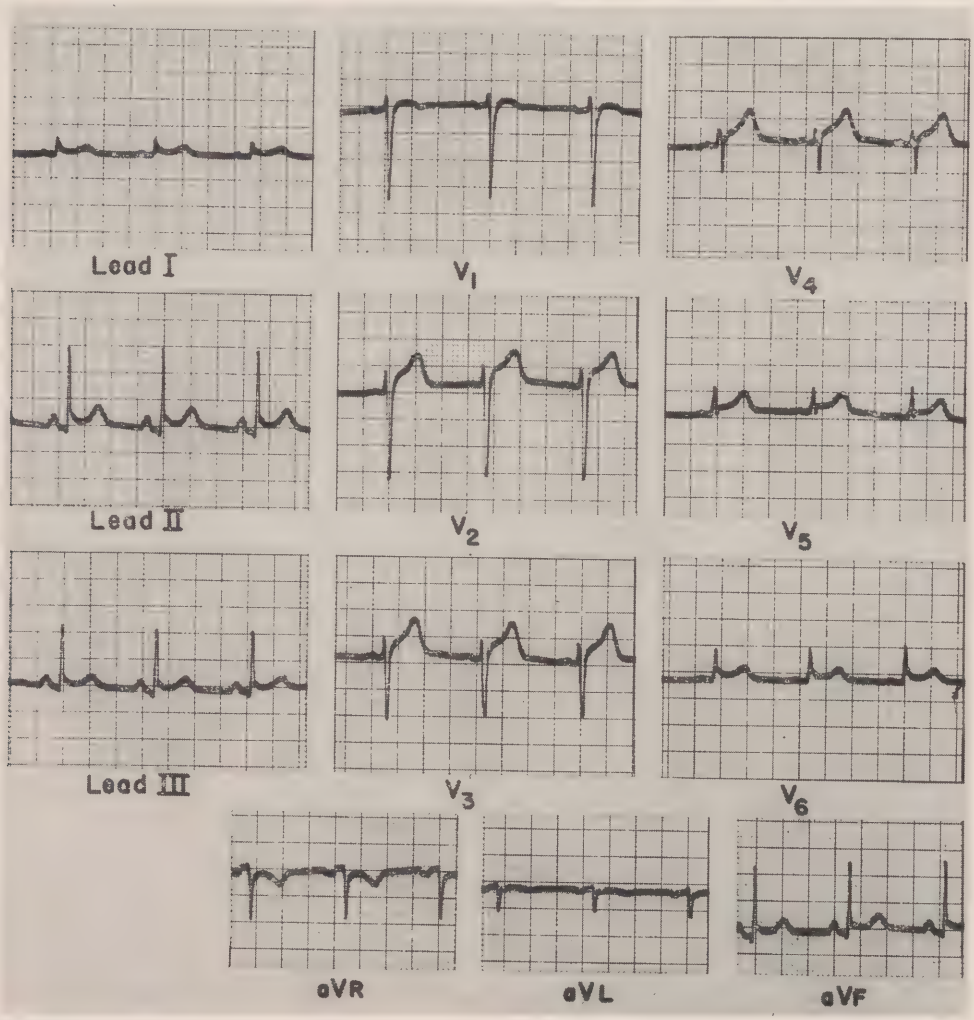
ELECTROCARDIOGRAM OF THE MONTH

Acute Non-Specific Pericarditis

DALE GROOM, M. D.
Department of Medicine

Case Record—A forty-five year old man was admitted to the hospital from the Emergency Room with a presumptive diagnosis of acute myocardial infarction. His history was that he had been awakened at 4 A. M. by a sudden, steady "crushing" type of substernal pain which radiated into both shoulders and the back of the neck and persisted with increasing severity. It was not accompanied by dyspnea or vomiting but the patient was said to have had a brief episode of syncope on the way to the Emergency Room. There his blood pressure and all vital signs were found to be normal and morphine sulphate (8 mg.) was given parenterally with considerable relief of pain.

This electrocardiogram is similar to several made during his ten day stay in the hospital. At no time did he have any appreciable elevation of temperature or white blood cell count. Serum transaminase determinations on three successive days were all within the normal range and the heart was observed to be of normal size and contour on P-A and lateral roentgenograms of the chest. A pericardial friction rub was audible on admission and for more than a week thereafter. The patient observed that the chest pain, which gradually subsided during the ensuing week, was accentuated by movements of the thorax and by deep inspiration.



His recovery was complete and uneventful.

Electrocardiogram—There is a regular sinus rhythm, normal P-R, QRS and Q-T intervals. Depolarization is directed toward the left leg electrode, the QRS deflections of aVR and aVL being negative ones.

Almost all leads show S-T segment elevations of 1 to 3 mm except in aVR where the S-T is depressed 1 mm. Amplitude of the QRS complexes in the left precordial leads is rather low but perhaps not unduly so with such a vertical axis.

Discussion—Many clinical features as well as the electrocardiogram of this case are typical of the acute pericarditis variously called "benign", "infectious", "viral" or simply "non-specific". Although it was described a century ago and is being recognized with increasing frequency, there is yet little but speculation as to its etiology and treatment. Its importance lies chiefly in differentiating it from acute myocardial infarction or one of the more serious types of pericarditis.

Electrocardiographically, the indications of any acute pericarditis are those of widespread injury to the subepicardial layers of myocardium, namely S-T segment elevations in virtually all the conventional leads except, usually, aVR which reflects more the subendocardial potentials and hence shows a reciprocal S-T depression. The oft noted upward concavity of S-T segments is well illustrated in the standard leads here. Following these acute changes (which are often quite transitory), the T waves may become diphasic or inverted, sometimes remaining so for many months. The ECG abnormalities of acute pericarditis, unlike those of infarction which is a localized lesion, are not confined to the anterior, posterior or diaphragmatic areas of the heart but rather depict widespread superficial involvement with, ordinarily, no QRS abnormalities other than perhaps reduction in amplitude (commensurate with reduction in the other complexes) in some cases with effusion.

A peculiar thing about the pain of acute non-specific pericarditis is its often abrupt onset, quite unlike what one would expect in an inflammatory process. Also suggestive of myocardial infarction is the frequently substernal location of the pain with radiation into the shoulders and neck. One distinctive feature, however, is that almost always the pain of pericarditis is accentuated by deep inspiration, coughing, swallowing or various movements of the thorax. Occasionally it is described as synchronous with the heart beat. It tends to be more variable in location and radiation than the pain of infarction, less severe, to subside more gradually and it is not ordinarily accompanied by the major disruptions in cardiac function which result from massive destruction of myocardium.

Like the ECG signs of acute pericarditis, the friction rub is notoriously evanescent. Heavy pressure of the stethoscope or the hand on the precordium will often bring it out as will changes in respiration or in position of the patient. Another helpful physical sign is the pulsus paradoxus, a perceptible waning of the pulse on inspiration, which can be demonstrated more objectively by observing a decrease in the blood pressure of 10 mm. Hg. or more during the inspiratory phase of respiration. Seldom in this type of pericarditis does effusion reach proportions sufficient to cause tamponade and require drainage but its presence accounts for the typical large heart with feeble or absent excursion of the borders on fluoroscopy or the typical "water bottle" contour on the upright chest film. Small amounts of fluid within the pericardium are difficult to detect so that a normal cardiac silhouette in no way rules out the disease.

Another aid in the differential diagnosis is the frequent temperature elevation of several degrees in the initial stage of acute pericarditis, in contradistinction to the normal temperature at the onset of infarction with no more than a low grade fever on subsequent days. This plus the fact that the non-specific pericarditis commonly comes on a week or so following a respiratory infection led early to the search for an infectious agent and recently to the Coxsackie B viruses, an etiology not yet proven. The absence of any fever or leukocytosis in this case is unusual.

For a while the tetracycline drugs were advocated as treatment for non-specific pericarditis but results of an antibiotic are difficult to evaluate in a disease which characteristically runs a benign course of a few days to a week or two (although exacerbations are not uncommon), subsides spontaneously and leaves little or no residua. The consensus now is that no therapy is specific nor is any required beyond symptomatic measures and management of occasional complications. Anticoagulants are of course contraindicated —an additional reason for differentiating early the acute pericarditis from myocardial infarction.

President's Page



As another year begins, it is my sincere wish that this will be the beginning of a bright, prosperous era for all of us. However, I know that it will begin with the maximum amount of fear and worry, as we begin to recoup to make that last payment of the 1961 estimated income tax. Then it will be starting all over again with the trying times of figuring the tax report for 1961. Only a very short breather until the beginning again of paying on the 1962 estimates and on ad infinitum.

There used to be times (only the oldest of us remember, however) when the new year brought forth hope and resolve that "this year would be happier, better financially and more secure. Those times seem ancient now, as we labor diligently to maintain what foothold we may have been able to obtain and must be content, for taxes and more taxes, we shall have with us "forever".

Along with this tax dreary time, too, we will be having to cope with legislation, inspired by political expediency, to further that feeling of lack of security, on our part, in order that scheming politicians may augment their ambitions to press, still further, down the road to socialism. By this I mean the King-Anderson Bill or any "Forand type" legislation. And again, it becomes necessary for us, as physicians, to fight for our existance as free men and Americans, to uphold a very essential freedom—"The Freedom of Choice".

It is my devout feeling that we must not only practice medicine, caring for our patients in the best way possible, but we *must* play the part of the Thomas Jeffersons, the Patrick Henrys, the George Washingtons and other of our founding forebears, to be sure that our patients are informed on these encroachments on *their* freedoms and rights.

I am not fearful of the medical care that the American people are, or may be getting, but I am gravely concerned about the governmental encroachment that they *are* and may be getting in the very near future. It behooves us, therefore, as doctors, to arouse ourselves as *citizens*, and become missionaries to try and save this country from the slowly but surely growing malignancy that stares us in the face with the convening of Congress this January.

Arouse, Citizen Doctors, and be counted.

Charles N. Wyatt, M. D., President
South Carolina Medical Association

Editorials

VOLUNTARY AGENCIES

Several years ago a committee of private citizens became concerned over the functioning of the many voluntary health and welfare agencies in the United States. They questioned whether they were not too numerous, whether they might be overlapping, actually competing, wasteful, unnecessary or otherwise undesirable. At the invitation of the Rockefeller Foundation, and with its financial support, this committee has made a study of the tremendous number of agencies whch request support from the public for a multiplicity of purposes. A report of this study has now been published.

It seems rather appalling to read that over 100,000 agencies on various levels now solicit contributions for their various charity purposes. Granting that the efforts of volunteer groups to achieve worthy ends by public support rather than a call on government funds is a very worthwhile philosophy, it would seem inevitable that these innumerable agencies would not all bear close inspection nor meet approbation of an unbiased committee. While this study is not reported in detail concerning every one of these agencies, it sets out certain general impressions and principles which have come from the investigation of the great many of them. One of the recommendations of the committee is that a new national commission be created—not a federal commission, but one that could develop criteria for better appraisal of the work of voluntary agencies.

The Committee was somewhat disturbed to find that some of the larger organizations studied do not have available financial records and believes that they owe the public a full accounting of funds collected. With this observation goes the natural suggestion that a uniform system of accounting be developed under expert guidance.

With the federal government now so largely engaged in the field of welfare, it seems particularly important that there should be close cooperative effort for the voluntary and the federal agencies. The national commission, if appointed, could study in depth the potential of the various councils and funds, could review planning, could oversee expenditures, could provide information to the public and in general attempt to coordinate all of the numerous efforts.

As one part of the many objectives which pertain to the voluntary agencies, the field of health has a stake of nearly a hundred million dollars ($100,000,000). The medical profession should be vitally interested in how economically these funds are raised and how logically they are distributed.

This interesting report on "voluntary health and welfare agencies in the United States" may be obtained for a $1.00 from the Schoolmasters Press, 82 Morningside Drive, New York 27, New York.

A BLOW TO CHIROPRACTIC

Back in 1957 the State of New York promulgated a regulation by way of the State Health Department that "no person shall apply radiation to a human being unless such person is licensed or otherwise authorized to practice medicine, dentistry, podiatry or osteopathy under the provisions of the Education Law of the State of New York." Obviously this applies to the chiropractors, who have always delighted in "x-raying" the patient from top to toe, and producing films which were generally of little or no value to anyone, except to the chiropractor by way of the enormous impression which this process made on his victims.

The legal processes adopted by the chiropractors have been grinding along for several years, but finally this summer the fight was lost and the x-ray machines and equipment must go out of the chiropractors' offices. This one measure removes the danger of harmful irradiation, and puts a decided dent into chiropractic prestige.

New York has set us an admirable example.

MORE NURSES AVAILABLE

But not enough. Although an estimated 73,565 new students were admitted to schools of professional and practical nursing in this country during 1960, this number represents an increase of only about 2,000 in the professional programs and only a few hundred in the practical nursing programs. However there was an increase in the number of practical nursing programs by some 54 units.

Seventeen per cent of the total enrollment in the professional group was in the college and university category and represents the elements aiming for bachelors degrees in nursing and presumably for teaching positions thereafter. Despite the employment of something over a half a million professional nurses, the shortage of nursing help is still glaring in many areas. The practical nurse has done much to fill the gap, but there is still none too many in this category. More schools or larger schools and more qualified teachers are essential in any attempt to meet the need for nurses.

And even with a considerable increase, there will still be a probable deficiency in bedside nursing. Perhaps that new type of nurse who is midway between the practical and the graduate may be a sort of answer to the problem.

WHAT'S THE PRICE OF MEDICINE?

It is encouraging to read that students of Jefferson Medical College Hospital in Philadelphia are learning to consider the cost as well as the medical need for ordering diagnostic tests and expensive drugs for hospital patients. Many people have been concerned with the unfortunate habit apparently inherent in hospital staffs of ordering a tremendous number of procedures and a large number of drugs, many items in both categories often of doubtful value, in an effort "to rule out" some suspected condition. Usually the selection is not meticulous, and the eager physician fills the order sheet with innumerable measures of very questionable value to the patient or to himself.

At Jefferson the students are given lists of standard charges for various procedures and tests, and they are required to maintain a running chart of the costs of the investigations ordered.

This is an approach which would not be amiss for many physicians in practice, and certainly for the coming crop of doctors it should be a valuable part of their hospital experience and if properly regarded should result in considerable saving to the patient and the hospital, as well as a more rational approach to diagnosis.

Another costly hospital custom lies in the disregard for the rapid progression of expensive hospital days which are sometimes required for some laboratory to make up its mind to do or report a certain test, or for some consultant to collect his dragging thoughts for expression. The total disregard of the patient's time, convenience and money is sometimes appalling in institutions where "science" reigns and common sense declines.

WATCH YOUR WORDS

Impressed with the multiple diseases of the vocabulary of medicine, some of which consist of multiplicity of meanings, inconsistent spellings, varying pronunciations, and so on, a group of people interested in the correction of these difficulties have formed a society which will endeavor by whatever means it can to bring matters to a better state.

Under the chairmanship of J. E. Schmidt, M. D., who is well known to many readers through his contributions in a lexicographical way, to newspapers, *Modern Medicine*, and other magazines, this National Association on Standard Medical Vocabulary can show an impressive advisory committee and an enthusiasm for performing a much needed task. This is a nonprofit organization of word-minded persons dedicated to the improvement of medical vocabulary in all its aspects. A medical Lexicopeia, a medical vocabulary style book, now in preparation, will serve as a reference guide in the matters mentioned.



Medical Television comes to South Carolina. A part of the audience at one show. Dr. Dale Groom, Master of Medical Ceremonies on the screen.

MEDICAL TELEVISION

On Noverber 30, 1961 the first medical television program went out over the closed circuit network extending into 68 schools all over South Carolina. Speakers on the symposium, "THE DIFFERENTIAL DIAGNOSIS OF CHEST PAIN", were Drs. Clarence Legerton, Eugene Smith, Jr., Rhett Talbert, and Dale Groom. Its format, which will probably be followed on subsequent programs, was that of a one hour discussion of the subject by the panel followed by thirty minutes of questions and answers, the questions being telephoned in by the viewing physicians on special telephone lines to the studio in Columbia. This is the first time that a state-wide closed circuit television network had been utilized for postgraduate medical education.

The programs are produced by the division of postgraduate education at the Medical College of South Carolina in cooperation with the staff of the Educational Television Center. In addition to members of the Medical College faculty, it is planned to present from time to time distinguished guest speakers on a schedule of once a month during the remainder of the academic year.

More than 300 physicians viewed the first television program. To date (1 week following the presentation) reports by mail and telephone give an accounting of 325 viewers for the two evenings, Thursday when it is presented live and Friday when a tape recording of the television program is sent out over the same network for physicians unable to attend the initial showing. Arrangements with the schools for viewing programs are made by the respective county medical societies. The programs have been approved by the American Academy of General Practice for 1½ hours Category I Credit each.

As the network continues to expand—and within a year or two it is anticipated that it will extend into every county of the State—more and more physicians will be able to participate in this new form of postgraduate education without the necessity of leaving their communities to travel long distances to scientific meetings. At present, an estimated 65% of the practicing physicians of South Carolina are within a few miles of one of the schools on the closed circuit television network. Letters and questionnaires from many areas where the first program was viewed indicate an enthusiastic response to what may well grow into a major activity of the Medical College of South Carolina and a precedent of national significance in postgraduate medical education.



Dr. Dale Groom.

The fourth of the current series of medical television programs over the closed circuit network extending into public schools throughout South Carolina will be presented on Thursday, February 1, 1962, from 8 to 9:30 P. M. with a repeated performance the following evening.

Title of the symposium will be "Peptic Ulcer" and the panel will consist of

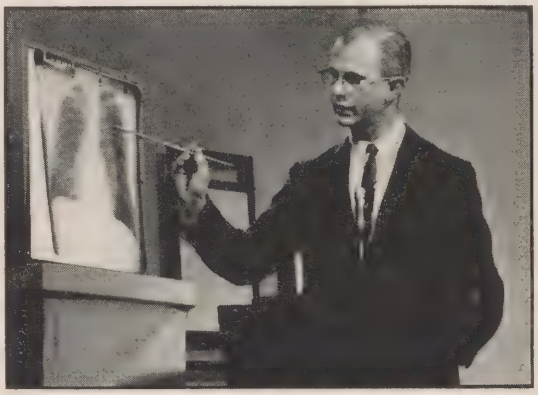
Dr. Vince Moseley
Dr. Randolph Bradham
Dr. Dale Groom — Moderator
Guest speaker: Dr. John T. Sessions
University of North Carolina Medical School.



Dr. Clarence Legerton, panelist.

Physicians may make their own arrangements with any of the following schools for viewing these medical television programs.

ALLENDALE
Allendale Training School
ANDERSON
Westside High School
McCants High School
BARNWELL
Barnwell High School
Butler High School
BISHOPVILLE
Bishopville High School
Dennis High School
BLACKVILLE
Blackville High School
Macedonia High School
BLANEY
Blaney High School
CAMDEN
Camden Junior High School
Camden Senior High School
Jackson High School



Dr. Eugene Smith, panelist.

CAYCE
Brookland-Cayce High School
CENTRAL
Daniel High School
CHARLESTON
Rivers High School
Simonton High School
CHARLESTON HEIGHTS
Chicora High School
CHESTER
Chester High School
CLEMSON
Calhoun-Clemson Elementary School
CLINTON
Clinton High School
COLUMBIA
A. C. Flora High School
Booker T. Washington High School
C. A. Johnson High School
Columbia High School
Crayton Junior High School
Dentsville High School
Dreher High School
Hand Junior High School
DARLINGTON
Brunson-Dargan High School
Saint John's High School
Mayo High School

EASLEY
Clearview High School
Easley High School
FAIRFAX
Allendale-Fairfax High School
FLORENCE
McClenaghan High School
Paynor Junior High School
Southside High School
Wilson Senior High School
GREENVILLE
Parker High School
Washington High School
GREENWOOD
Brewer High School
Greenwood Senior High School
HARTSVILLE
Hartsville High School
Hartsville Junior High School
LANCASTER
Lancaster Senior High School
MANNING
Manning High School
Manning Training School
PICKENS
Pickens High School
PROSPERITY
Mid-Carolina High School
ROCK HILL
Emmett Scott High School
Rock Hill High School
Winthrop Training School



Dr. Rhett Talbert, panelist.

SPARTANBURG
Carver High School
Cleveland Junior High School
Cumming Street Junior High School
Frank Evans Junior High School
Jenkins Junior High School
Roebuck High School
SUMTER
Alice Drive Junior High School
Edmunds High School
McLaurin High School
Lincoln High School
SWANSEA
Swansea High School

Medical Television

Local medical societies of the state who participated in the first South Carolina Medical College symposia over the state's educational television network are unanimous in wanting a continuation of a series of in-service training programs, according to a survey conducted by the Medical College and the South Carolina ETV Center.

Responding to wishes of the doctors, more than 325 of whom sat in at 13 high schools over the state for the first subject, "Differential Diagnosis of Chest Pain," the Medical College presented its second ETV discussion, entitled "Headache."

The teaching panel for the program included Dr. Dale Groom, moderator; Dr. Cheves M. Smythe, Dr. William Vallotton, Dr. O. Rhett Talbert and Dr. Ramsey Mellette. The telecast originated in the South Carolina ETV Center in Columbia.

Viewing doctors in the school buildings in their home towns are connected with the studio by telephone hookup and are able to ask questions of the teaching panel in a summary session. The lesson and follow-up last an hour and a half.

Samples of the comments of medical societies urging continuation of the ETV project in reply to the question, "What was the reaction of viewing doctors?" included the following: "We had one hundred per cent of the doctors . . . the audience reaction was terrific in that everyone's attention was held throughout," "excellent and enthusiastic," "excellent and very informative, would like to continue," "It is certainly a milestone in medical education" and others.

Attendance at the schools represented more than 20 per cent of the practicing physicians of the state.

Doctors in the following cities gathered in their schools for the second training course: Charleston, Columbia, Camden, Sumter, Florence, Darlington, Spartanburg, Barnwell, Chester, Greenwood, Clinton, Lancaster, Rock Hill, and Greenville.

Doctors in other localities reached by ETV may include themselves by making arrangements with their local school authorities.

News

State Board of Medical Examiners of South Carolina

The State Board of Medical Examiners of South Carolina met on November 7, 1961 in the English Room of the Columbia Hotel, Columbia, South Carolina, to interview applicants for a medical license by endorsement of credentials. Sixteen physicians were licensed to practice medicine and surgery in the State of South Carolina. They are as follows:

Dr. Leon P. Andrews is a graduate of Harvard Med. School, class of '45. He holds a certificate from the National Board and is licensed in North Carolina, where he was in the practice of internal medicine in Fayetteville. Dr. Andrews is now Director of Medical Education at Greenville General Hospital.

Dr. James L. Bland is a 1960 graduate of the Med. College of Ga. He is licensed in Georgia. Dr. Bland completed his internship in June and is now in the United States Army. His home is in New Ellenton.

Dr. John U. Bures, a graduate of Marquette School of Med. ('57), is presently in St. Petersburg, Fla. Dr. Bures spent two years at Greenville Gen. Hosp. training in Obs. and Gyn. before continuing his training in Florida. He plans to begin practicing in Charleston early in 1962. Dr. Bures is licensed in Wisconsin.

Dr. Berryman E. Coggeshall, Jr. is a graduate of Duke Univ. School of Med., class of '52. Dr. Coggeshall is licensed in Louisiana and has a National Board certificate. He served a residency in surgery at Tulane. He now does general surgery at the Chesterfield County Hosp. in Cheraw.

Dr. Everett L. Dargan is a 1953 graduate of Howard Univ. Col. of Med. He served a residency in surgery in New York, where he is also licensed; his endorsement was through the National Board. Dr. Dargan has his office at 2120 Hampton St. in Columbia.

Dr. Henry R. Ennis, a graduate of the New York Med. College ('41), is currently in the United States Navy in Charleston. Dr. Ennis is certified in orthopaedics. He has a certificate from the Navy Board and is licensed in California. Dr. Ennis, after 20 years in the Navy, plans to begin practicing in Camden early in 1962.

Dr. Donald M. Gelb, Chicago Medical School class of 1959, has residency training in internal medicine. He has a certificate from the National Board of Medical Examiners. Dr. Gelb is in general practice at 234 S. Dargan St. in Florence.

Dr. George W. Houck is a graduate of Jefferson Med. College ('43). He took a residency in psychiatry while serving six years in the United States Army. Dr. Houck is licensed in California, Penna., Nev., and Mo. He is Psychiatrist-Director of the Mental Health Center for Darlington and Florence Counties, located in Florence.

Dr. Robert G. Janes graduated from the Univ. of West. Ontario in 1926. He served a residency in radiology and has practiced in Michigan and Ohio, and is licensed in both states. Dr. Janes is a radiologist at the V. A. Hospital in Columbia.

Dr. Helen H. Kuglar is a 1957 graduate of the Univ. of N. C. School of Med. She served a residency in Obs. and Gyn. at Talmadge Hosp. in Augusta and is licensed in Georgia. Dr. Kuglar recently joined the staff at S. C. State Hosp. as a psychiatrist.

Dr. John S. Meyer graduated from Wash. Univ. School of Med. in 1956. He took a residency in pathology in St. Louis, Mo. and holds a license in that state. Dr. Meyer is currently in the United States Navy at the U. S. N. Hospital in Beaufort.

Dr. Christina Y. Parr is a graduate of Temple Univ. School of Med. ('51). She served a residency in Obs. and Gyn. in Chicago, and is certified by the National Board of Medical Examiners and licensed in Illinois. Dr. Parr recently returned to Columbia after three years in Iran.

Dr. Edmond L. Rice is a 1931 graduate of Emory Univ. School of Med. He took residency training in surgery following his internship. He has a certificate from the National Board and is licensed in Ga. and N. C. After serving the past seven years in Pakistan he is now practicing at 227 Pendleton Rd. in Clemson.

Dr. Charles W. Simmons graduated from Howard Univ. Col. of Med. in 1956. He has residency training in medicine and is licensed in Maryland. Dr. Simmons has an office at 129 Congress Street in Charleston where he practices Internal Medicine.

Dr. William S. Skaryd is a 1941 graduate of West. Reserve Univ. School of Med. He is licensed in Ohio and has served a residency in anesth. Dr. Skaryd practiced in Ohio before opening his office at the Professional Building in Spartanburg.

Dr. Robert W. Youngblood graduated from Johns Hopkins Univ. School of Med. in 1955. He has served a residency in surgery and holds licenses in Miss. and Tennessee. Dr. Youngblood is in the United States Navy and is stationed at the U. S. Navy Hospital in Beaufort.

The State Board of Medical Examiners of South Carolina held written examinations at the Columbia Hotel on November 7, 8, 1961. Five physicians passed the examinations and have been licensed. They are:

Dr. Eric M. Dreyfuss, a 1957 graduate of the Chicago Med. School, is currently in the United States Army at Fort Jackson.

Dr. James F. Glenn, a 1953 graduate of Duke Univ. School of Med., is an instructor in the Dept. of Urol. at Bowman-Gray School of Med. in Winston-Salem, N. C.

Dr. Theodore J. Kocak, a graduate of Temple Univ. School of Med. ('61), is at present an intern at Charlotte Mem. Hosp. in North Carolina.

Dr. Victor L. Kruger, a 1918 graduate of the Univ. of Budapest Med. School, is a surgeon at the S. C. State Hospital.

Dr. William M. Rambo, a graduate of the Univ. of Pa. School of Med. in 1958, is a resident in surgery at the Medical College Hospital in Charleston.

Symposium on Computers' Role in Cardiovascular Disease

A nationwide effort to link the almost limitless possibilities of modern computers to research and diagnosis in cardiovascular disease will be launched in Philadelphia early this year by the Heart Association of Southeastern Pennsylvania. (318 South 19th St., Phila. 3, Pa.)

On February 27 and 28, 1962, experts in computer analysis and programing will foregather with their counterparts in medical and other life sciences for a national symposium on how best to use the so-called electronic "brains" to conquer heart and circulatory diseases, the nation's No. 1 killer.

Coastal Medical Society

The regular meeting of the Coastal Medical Society was held at The Southland Diner, Walterboro, S. C., Thursday the 14th of December, 1961. Guest speakers were Dr. Charles N. Wyatt and Mr. M. L. Meadors.

Winthrop Adds Med Technology

Plans are underway at Winthrop College for the establishment of a cooperative program of study for medical technologists.

Announcing the plans, Dean Walter D. Smith said the cooperative program between Winthrop and leading hospitals of the area is being planned to help fill the tremendous need for medical technologists.

Currently, Winthrop students who enter this area of medicine attend school an extra year after graduation to qualify as laboratory technicians.

On completion of the new program, a student will attend Winthrop for three years, meeting all general education requirements and required courses in biology, chemistry and other sciences.

She will then go to a hospital such as the Charlotte Memorial Hospital or the Medical College of South Carolina Hospital where she will receive technical medical training and continue her program of daily class work.

The study in the hospital will continue for a year or until such time as she is qualified for professional certification.

In addition to her professional certificate, she will receive also the bachelor's degree from Winthrop College on completion of her medical technology training program.

Aynor Clinic Staffed

The Aynor Health Center Clinic is now staffed three afternoons a week by Dr. Daniel W. Martin, Dr. Herman F. Maron and Dr. Franklin Cox, all of Mullins. The Clinic is open Monday, Wednesday and Friday afternoons from 1 p. m. to 5 p. m.

Three Named to Anderson Health Board

Dr. John C. Taylor of Honea Path, and Dr. Charles H. Browne and Dr. S. Earle Wardlaw, of Anderson, have assumed posts on the Anderson County Board of Health. Dr. Taylor, an appointee of the Medical Society replaces Dr. Leo Davidson who resigned. Dr. Browne was appointed by the Tuberculosis Association to succeed the late Dr. Clinkscales. Dr. Wardlaw is the appointee of the Dental Society.

Man and Woman of the Year

Dr. Harold S. Gilmore has been elected "Man of the Year" by the Nichols Civitan Club. He is the first person ever chosen for this honor by Nichols citizens.

Dr. Josephine Young Sullivan of Burgess Hill, wife of Dr. Francis Sullivan and mother of five children, was named Greer's "Woman of the Year for 1961" by the Greer Business and Professional Women's Club. Dr. Sullivan has been associate in Anesthesiology at the Allen Bennett Memorial Hospital since 1954.

Dr. Hunt To Practice In Columbia

Dr. Rexford H. Hunt, Jr. has begun practice in general surgery in Columbia.

A graduate of the University of South Carolina and the Medical College of South Carolina, Dr. Hunt served his internship in Philadelphia at Temple University Hospital. He also took four years of special training at Temple.

His pediatric surgical training was completed at St. Christopher Hospital for Children in Philadelphia.

In 1959 he was awarded a Doctor of Science in Surgery degree.

Dr. Hunt has other post graduate work to his credit and was selected as a clinical fellow of the American Cancer Society from 1957 to 1959.

He served in the Navy the past two years as a surgeon aboard the U.S.S. Saratoga, as a member of the surgical staff of the Naval Hospital in Portsmouth, Va. and a member of the surgical staff of the National Naval Medical Center at Bethesda, Md.

Dr. Timmons Elected Chief of Hartsville Hospital

Dr. George L. Timmons has been elected chief of staff of The Byerly Hospital to succeed Dr. Barney F. Timmons. An anesthesiologist, Dr. George Timmons is associated with Dr. W. L. Byerly, Sr. in general practice at the Byerly-Timmons Clinic.

Dr. Durst Named to Head Chamber

Dr. George Gardner Durst, a Sullivan's Island physician was elected president of the Greater Charleston Chamber of Commerce recently.

W. F. Young Admitted to Academy of Pediatrics

Dr. William F. Young, a native of Florence now living in Sumter, has been elected a fellow of the American Academy of Pediatrics.

American Academy of General Practice

The 13th annual Scientific Assembly of the South Carolina Chapter of American Academy of General Practice met October 12, 1961, at the Clemson House for a two-day session.

The academy chose Dr. J. H. Cutchin of Easley as its president-elect, elevating Dr. Swift C. Black to the presidency for a year. Dr. Martin Teague of Laurens is outgoing president.

Others elected were Dr. J. M. Townsend of Charleston, vice president; Dr. William J. Bannen, Jr. of Simpsonville, secretary, and Dr. J. W. Blanton of Chesnee, treasurer.

Directors chosen were Dr. R. L. Crawford of Lancaster, Dr. Halsted Stone of Chester, Dr. D. O. Winter of Sumter and Dr. Horace M. Whitworth of Greenville.

Dr. Whitworth was named to the Ross Awards Committee and Dr. George Price of Spartanburg to the nominating committee of the American Academy of General Practice.

The academy chose to meet next year in Charleston.

Dr. Groom Initiated in A. O. A.

Dr. Dale Groom was initiated into the Alpha Omega Alpha honorary medical fraternity at his alma mater, The Medical College of Virginia, in Richmond November 10th, 1961.

Griggs Named Union Memorial Chief of Staff

Dr. D. C. Griggs of Pageland has been elected Chief of Staff at the Union Memorial Hospital in Monroe.

This is the first time in the hospital's history that an out-of-county, out-of-state physician has been chosen for this post.

Griggs, who came to Pageland from the Medical College in Charleston in 1925, has delivered over 8,000 babies. Prior to his election as chief of staff, he was in charge of the hospital nursery.

Health Board Reports Anthrax

A case of anthrax, a rare disease caused by contact with goat hair, has been reported to the State Board of Health.

The case, which occurred in Dillon County, is the 17th in that area in the last year and a half but the first since December 31.

Anthrax is an external ulcer caused by infection from imported goat hair. A Dillon plant uses this hair to make inner lining for suits.

A vaccine program at the plant has controlled the disease. The person infected this week had had only one injection, which is not sufficient, according to Dr. G. E. McDaniel, director of the Division of Disease Control.

Chemstrand Names Physician For Plant

Dr. Thomas Stanley of Pensacola, Fla., will become plant physician at the Chemstrand Corporation's Greenwood County nylon plant January 1, according to R. L. Granger, director of nylon manufacturing at the local plant.

Dr. Stanley has been plant physician at Chemstrand's Pensacola nylon manufacturing facility since September 1, 1957.

Dr. Stanley was a civilian physician at the Naval Air Station at Jacksonville, Fla., for two years prior to joining Chemstrand. He was in private practice at Jacksonville Beach before that.

He is a native of Wilkes Barre, Pa., and attended Georgetown University, where he received his medical degree in 1936.

He is a member of the Escambia County, Fla,. Medical Association, the Florida Medical Association and the American Medical Association. In 1936, he was named a diplomate of the National Board of Medical Examiners.

Dr. Betty Wood To Open Office

Johnston's first woman doctor, Dr. Betty Jean Wood, opened her office at 104 Doughty Street in Charleston November 15th.

After graduating from the University of South Carolina in 1953 and from the Medical College of Charleston in 1956, Dr. Wood interned for one year at the Los Angeles County Hospital in Los Angeles, California. She served her residency in ophthalmology at Charity Hospital in New Orleans from 1958 to early 1961. Following several weeks as locum tenens in Oakland, California, she took the Lancaster Basic Science Course in ophthalmology at Waterville, Maine, which she finished this past September.

Dr. Wood will treat eye conditions and diseases only.

Dr. Hart Named To Blood Center Post

On December 1, the Richland County Chapter of the American Red Cross acquired the services of Dr. W. A. "Gus" Hart as medical director of its Regional Blood Center.

Dr. Hart will have his office at the Red Cross Chapter House, 1100 Shirley Street. He will be in charge of the laboratory where blood from volunteer donors is processed, stored and distributed, and will travel with the Bloodmobile to supervise the collecting of blood.

Fellowships in Maternal and Child Health Harvard School of Public Health Maternal and Child Health Department Boston, Massachusetts

The Department of Maternal and Child Health of the Harvard School of Public Health announces two

Fellowships for the year 1962-1963 for physicians who have completed in full or in part the residency requirements for certification by the American Board of Pediatrics or the American Board of Obstetrics and Gynecology.

The one-year program leads to the degree of Master of Public Health and is one of the requirements for certification by the American Board of Preventive Medicine. The Fellowships may be extended for a second year for those who wish to undertake advanced study and research and who meet the qualifications. Such research, if appropriate, may serve to fulfill the requirements, in part, for a doctoral degree in public health.

The Fellowships cover tuition and fees, an allowance for travel, and a monthly stipend of $400 plus $80 a month for each dependent during the period of study.

Inquiries should be sent to Dr. William M. Schmidt, Professor of Maternal and Child Health, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Massachusetts, preferably before April 1, 1962.

Columbia Medical Society

The February Scientific Meeting of the Columbia Medical Society will be held Monday, February 12, 1962, at 7:00 P. M. at the Columbia Hotel.

The guest speaker for this meeting will be Dr. Clifford E. Nelson, Division of Radiological Health, Department if Health, Education, and Welfare. Dr. Nelson will discuss the Public Health Service radiation control program, and some aspects of the control of radiation hazards in the healing arts, as reflected in the State radiation control programs currently under way in this nation.

The local speaker will be Dr. Thomas E. Edwards, orthopedic surgeon of Columbia, who will speak on "A Case of Parathyroid Adenoma with Removal and Two Year Follow-up".

All interested physicians are invited to attend the meeting.

B. Jean Wood, M. D.
announces the opening of her office
for
OPHTHALMOLOGY
at
102 DOUGHTY STREET
Charleston

Medical Assemblies

The Richmond County Medical Society of Augusta, Georgia will hold its Postgraduate Medical Assembly April 2-4, 1962. The registration fee of $15.00 covers sessions and a cocktail party.

Since this coincides with practice rounds of the Masters Golf Tournament, all those interested are requested to register early.

Write: Julius T. Johnson, M. D., Chairman
Postgraduate Medical Assembly Committee
P. O. Box 3323, Augusta, Ga.

Diet Notes

Leading medical nutritionists state that overweight is one of the most outstanding problems in nutrition today. Neither the American Medical Association nor the American Dietetic Association sanctions "crash" liquid diets or other current fad diets. Although persons on these diets may have rapid weight loss, they usually do not stay "reduced" when they return to their usual eating patterns.

Simple, one-page 1000, 1200, and 1500 calorie diet lists may be obtained in moderate quantities, on request. It is recommended that a vitamin supplement be given with these diets.

Write to: Margaret Freeman, Dietitian
Medical College Clinic
Charleston 16, S. C.

Heart Disease Control, State Board of Health

The 25th annual meeting of the New Orleans Graduate Medical Assembly will be held March 12-15, 1962 in New Orleans headquarters at The Roosevelt Hotel. For reservations write:

The New Orleans Graduate Medical Assembly
1430 Tulane Avenue New Orleans 12, La.

After the assembly there will be a 22 day clinical tour to the Mediterranean.

The 30th annual assembly of the Southeastern Surgical Congress will be held March 5-8, 1962 with headquarters in the Brown Hotel, Louisville, Ky. This assembly will also have a four day nurses' section, running concurrent with the general program. For further information wirte:

A. H. Letton, M. D., Secretary
The Southeastern Surgical Congress
340 Boulevard, N. E. Atlanta 12, Ga.

Doctors — Ministers — Lawyers

The good will that exists between South Carolina doctors, lawyers and ministers was exemplified by three meetings held last October and November. The Summerville Ministerial Association invited the doctors of Summerville to a dinner as an expression of gratitude for the cooperation rendered by the local doctors in ministering to patients at the Dorchester County Hospital. In Spartanburg Dr. Richard Young, professor of Pastoral Care at the Bowman-Gray Medical School and North Carolina Baptist Hospital was guest speaker at the monthly meeting of the Spartan-

burg County Medical Society. The Spartanburg Ministerial Association also attended the meeting. In Bennettsville the Marlboro County Medical Society was host to the annual Pee Dee Medical Society's doctor-lawyer banquet meeting. Former practicing attorney, Gov. E. F. Hollings, was guest speaker.

Dr. Vincent Re-opens Office

Dr. Charles P. Vincent, Jr. re-opened his office for the practice of General Medicine and Cardiology on November 1, 1961, at 1113 Mill St., Columbia.

Dr. Cantey Heads Chapter Of Surgeons

Dr. William C. Cantey of Columbia has been elected president of the South Carolina Chapter of the American College of Surgeons.

Dr. William Brockington of Greenwood is the new vice president of the chapter; Dr. James T. Green, secretary and treasurer, and Dr. Norman D. Ellis, a new executive committeeman.

E. L. Dargan Opens Practice

Dr. Everett L. Dargan has begun the practice of surgery at 2120 Hampton St. in Columbia.

A native of Columbia, Dr. Dargan was graduated from the Howard University School of Medicine with the highest scholastic record in all courses in medicine and was elected to the Kappa Pi Medical Honor Society. He interned in The Kings County Hospital Medical Center in Brooklyn, New York. He then became a Resident in surgery at the Harlem Hospital in New York.

In 1955 Dr. Dargan entered the United States Air Force, was sent to England, attained the rank of Captain and served as a Squadron Commander and the Base Surgeon to the 3910th USAF Air Base Group.

Receiving an honorable discharge from active duty, Dr. Dargan returned to formal surgical training at The Albert Einstein Medical Center in New York.

In 1960 he was named Chief Resident Surgeon at the Bronx Municipal Hospital Center and assistant instructor in Surgery at The Albert Einstein Medical School. He has published several scientific papers dealing with basic and clinical surgical problems, and was awarded a Training Fellowship by the American Cancer Society. He has presented scientific papers before the American College of Surgeons and the American Medical Association. He is a diplomate of the National Board of Medical Examiners and a member of the Candidate Group of The American College of Surgeons.

Civil Defense

"There would probably be millions of casualties."

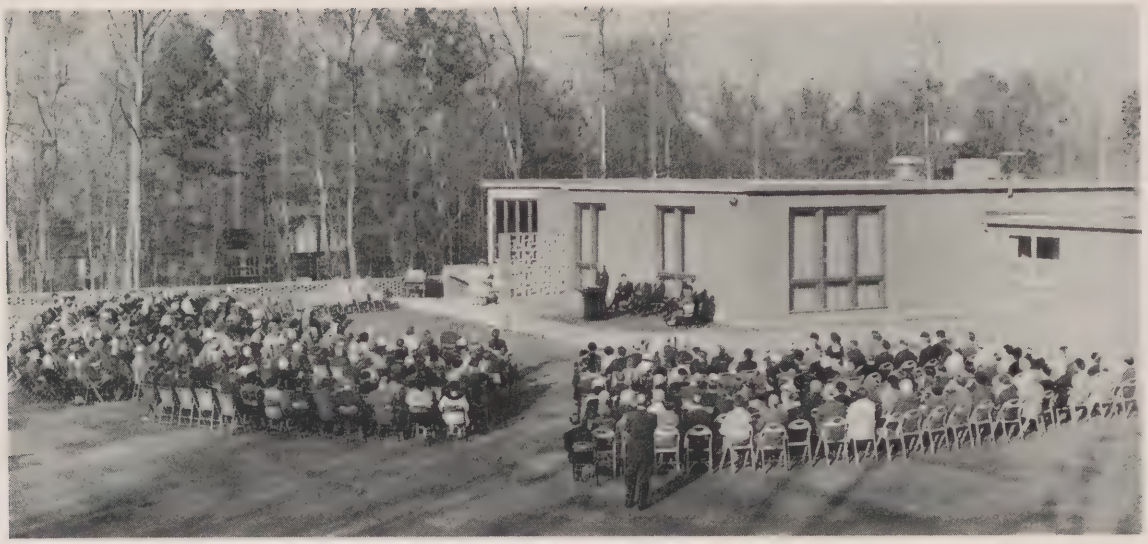
Regardless of who the speaker may be—adherent or critic of Civil Defense—on one thing they all agree: a thermonuclear attack on this nation would cause an inestimable number of casualties.

In the immediate target area complete devastation would result. And outward from the target area, in an area dictated by the kiloton or megaton rating of the weapon, heat and blast effects would cause trauma, burns and a combination of both.

But for those removed from the damage zone, there is another factor to be considered—radioactive fallout. Much of what has been written about fallout has been misleading rather than informative. We hope the following explanation of the persistency of the hazards from fallout will eliminate any misconceptions concerning this vital problem.

Although fallout from nuclear war would probably be widespread, the areas of intense contamination would be relatively limited. Further, the radioactivity of fallout would decrease or decay rapidly and within two weeks after a nuclear weapon attack the fallout situation would be tolerable over most of the national land area. In those limited areas where the contamination did not decay to tolerable limits within two weeks time, the fallout would have decayed sufficiently at least to permit departure from shelter and evacuation from the area for a period of a month or so until reoccupancy would become feasible. Actually, two weeks after attack the level of radiation will have decayed to about 1/1000th of the level that would exist one hour after detonation. Although the environment would continue to be somewhat hostile for several months postattack, the situation would not be unmanageable. It would definitely not be hopeless and those who survived the first few weeks would adjust to the situation and contribute effectively to the recovery of the Nation.

Strontium 90 and cesium 137, which have half-lives of about 28 years, would continue to be troublesome for many years after a nuclear attack. But these isotopes would not render existence impossible. One of the longest lived isotopes, uranium 238, which has a half-life of about five billion years, has been on this earth in quite abundant amounts from the time of the earth's formation. Actually, this isotope is mined and used as one of the fuel elements in a thermonuclear weapon. However, in spite of this radioactive material which has always been with us, man has thrived and developed for thousands of generations.



Dedication of the Grace White Memorial Nursing Pavilion.

The new $500,000 Grace White Memorial nursing pavilion and convalescent home, an addition to the facilities of the Marion Sims Memorial Hospital in Lancaster, was formally dedicated before an audience of 400 distinguished guests from North and South Carolina Sunday, December 7, 1961.

Among the principal speakers at the ceremonies were: former Governor James F. Byrnes; Ben C. Hough, president of the board of directors of the Marion Sims Hospital; Dr. J. P. Horton, chief of the hospital medical staff; H. W. Close, son-in-law of Colonel E. W. Springs and president of The Springs Cotton Mills, and Dr. G. E. McDaniel.

As a representative of the State Board of Health, Dr. McDaniel described the interest state medical authorities were taking in the new facility. He pointed out that it was the first nursing home in the state to be built for operation as a part of a general hospital and expressed the hope that this pattern would be followed all over South Carolina.

The 40-bed facility contains 21 rooms, spacious lounges and open areas plus special rooms for physical therapy, food preparation and treatment. Funds for its construction came from an entitlement under the Hill-Burton Act, the Duke Endowment and the Springs family through the Springs Foundation.

Poliomyelitis in South Carolina and Poliomyelitis Vaccines

G. E. McDaniel, M. D., Director
Division of Disease Control
State Board of Health

Cases of poliomyelitis in South Carolina have occurred at a lower incidence since general use of polio vaccines began in late 1955. Cases have continued to occur in the usual annual up-and-down pattern, but cases in the two highest years in the last five have not been as many as were in the two highest years in the two preceding five-year periods. During these two five-year periods preceding the introduction of vaccines, the average annual number of cases was 200 for the period 1946-1950, 221 for the period 1951-1955, and 98 for the period since vaccine, 1956-1960. More than two and one-half million doses of the Salk-type vaccine have been distributed, and the county health departments have carried on extensive immunization campaigns. Yet small localized outbreaks continue to occur, usually in areas and among populations with low immunity levels.

Other disappearing diseases such as malaria, diphtheria and hookworm behaved in a similar manner. It is necessary that medical and health officers locate these islands and get them protected in order to prevent further outbreaks. One such outbreak occurred in the Cherokee-Spartanburg-Union area in 1960, and another localized outbreak occurred in Newberry County this year. Of the 32 cases in South Carolina this year through October 28th, 22 have been in Newberry County. Sixteen of these occurred after September 1st, and 18 of the 22 have been paralytic. There have been two deaths. One of only two adult cases was a 20-year-old Negro male and the other a 32-year-old white male. The other cases were in the following age groups: 0-4, 5 cases; 5-9, 11 cases; 10-14, 4 cases. Nineteen of the cases were in the Negro race, and 16 had had no vaccine. Three of the cases, including the adult fatal one, had had three or more doses of vaccine. The Newberry County Health Department had conducted intensive immunization campaigns from 1955 to 1957, but response of the public had been less during the last two years.

The first five cases had been determined by laboratory examinations to be of Type III poliomyelitis and with tentative isolations from two adult cases. This type has now been isolated from 18 of the cases.

Since this was a specific Type III outbreak and had involved chiefly one area and segment of the population, it was determined to apply for Type III oral vaccine to be used as a type-specific outbreak control measure. A total of 25,000 doses was obtained from Dr. Sabin of Cincinnati, Ohio. This vaccine was reconstituted in the State Board of Health Laboratory and put into dropper bottles with a capacity of 50-60 doses and with droppers graduated to deliver exactly 0.1 cc. (one dose) in two drops when the dropper was held perpendicular. The oral attenuated live virus vaccine has the advantage of producing antibody response in a few days and of producing resistance in the intestinal canal cells to invasion of wild Type III viruses. It, however, protects only against Type III virus. The community response was phenomenal in that 21,200 persons received the vaccine from a total population of 29,416. All of the vaccine was administered with what is thought to be minimum loss in eighteen different clinics in the county.

The mechanics of organization, distribution and administration of the vaccine was developed by the County Health Department and the County Medical Society. Many county professional and lay groups cooperated. The unusual success of the program was a result of this detailed organization and due to the total community cooperation and coordination.

Only Types I and II attenuated live virus vaccine is licensed at present, and indications are that it may be several months before Type III vaccine is licensed. The use of the oral vaccine needs much careful consideration before use; and until all three types are readily available, its best public health use is in the control of type-specific outbreaks.

Deaths

Dr. James H. Hunter

Dr. James Harris Hunter, 84, died November 6 in Spartanburg after a long illness.

A native of Mecklenburg County, N. C., Dr. Hunter graduated from the University of Tennessee Medical College in 1908 and was honored by the university in 1958. Also in 1958 the County Medical Society selected Dr. Hunter for its top award, "Doctor of the Year." At this time he had completed 50 years as a general practitioner.

Dr. Charles J. Lemmon

Dr. Charles J. Lemmon, surgeon and businessman, died October 29 at his home in Sumter at the age of 78.

Dr. Lemmon served as chief of staff at Tuomey Hospital for many years and was a member and former president of the Sumter County Medical Society and a member of the S. C. and American Medical Association. He was a fellow in the Southeastern Surgical Conference.

A graduate of Clemson College, he went on to graduate from the Medical College of S. C. He did further study in the Mayo Clinic in Rochester, Minn., and at New York and Harvard post graduate schools. He was a member of the Kappa Sigma Fraternity and received the charter for Alpha Kappa Kappa Fraternity at the Medical College of S. C.

Dr. Lemmon was a leader in the educational and civic development of the community. He was a member of the District 17 board of education and its chairman for many years. He was also a member and longtime deacon of the First Presbyterian Church in Sumter.

Dr. Charles Harrell

Dr. Charles Harrell, 88, of Rock Hill died September 28 after several months of declining health.

Dr. Harrell was born and reared in Stewart County, Ga. He was a graduate of the Emory Medical School. After serving in the Spanish-American War, he began his practice in Georgia in 1900 and moved to Rock Hill in 1925. He practiced medicine in Rock Hill until retiring in 1958. He was a member of the York County Medical Society and both the South Carolina and Georgia Medical Associations.

Dr. Humphrey Bates Williams

Dr. Humphrey Bates Williams, 80, died October 15 in Columbia after several years of illness.

Born in Honea Path, Dr. Williams was a graduate of Vanderbilt University. After serving his internship, he practiced medicine as a general practitioner in Honea Path until 1931, when he came to Columbia. He practiced medicine in Columbia until his retirement in 1957.

Dr. Williams was past president of the Anderson County Medical Society, was a member of the Columbia Medical Society, the South Carolina Medical Association and the American Medical Association.

Public Relations

Throughout the past year, the core of the S. C. Medical Association's public relations program has been centered in its speakers bureaus, operating through 22 county societies. In many instances these bureaus have been gratifyingly active. They have used their opportunities fully to explain their work . . . to outline their plans for future progress in state-wide medical care . . . and to show themselves good citizens as well as fine physicians.

A year-end check shows that approximately 100 speeches were made throughout the state. The effectiveness of this program, and the potential it would have if it were actively pursued by all 38 county societies, is indicated in these comments:

"I sincerely appreciate your sending me a copy of the speech on *The Care And Preservation of the American Businessman.* This will be a big help to me in making a speech to the Newberry Rotary Club on the 13th. If everything goes as scheduled, this speech will also be live broadcast on WKDK, Newberry." (Dr. Ralph Baker, Newberry, Oct. 15).

"We are setting up our Speakers Bureau in Oconee and have already spoken to four organizations with more in the offing." (Dr. J. P. Booker, Walhalla, Oct. 25).

"We had considerable success with our local medical talks. Practically all of the service clubs have been favored by local doctors. The response on the part of the members has been most complimentary." (Dr. Phillips L. Bates, Greenwood, June 6).



During the fall an investigation was made of the practicality of producing on tape, messages from physicians throughout the state, on socio-economic and other topics of community interest, to be placed in the public service time segments of major radio stations.

The stations have been most receptive to this tentative proposal. Public service time is offered without charge. Therefore, the only costs would be the nominal fees for production of tapes.

As a test, a message of general interest was written and produced early in December. Dr. Charles N. Wyatt, president of the Association, gave the message on the dangerous socialistic undercurrents surrounding medical legislation to be presented to Congress this year.

So far this tape has been placed on six stations. An expansion of this program is planned for the coming year, with a public relations staff member visiting county societies for on-the-spot taping of problems relating directly to each community.

looking ahead . . .

1962—THE CRUCIAL YEAR

"Heavy Push Planned for Medicare"

"National Whirligig" reprinted in *Charleston Evening Post*

"The Big Battle of Your Lives"

Editorial, *The Dallas News*

Rep. Wm. Jennings Bryan Dorn—letter to Dr. John P. Booker, July 13.

"Socialized medicine will again rear its sinister head here in the Congress next spring with tremendous pressure from the Administration and highly organized propaganda machines."

"All of us must keep this issue alive before our people . . . we must inform and educate at the grass roots."

These quotations are but a few of many, pointing toward an all-out push to be made by the supporters of socialized medicine. They are not "scare" headlines, nor is the threat a vague, off-in-the-future thing. This threat faces the American Medical profession today. It faces every physician in the nation, regardless of his location.

There has been some complacency in South Carolina, and not without cause. A favorable press, a sympathetic public, a fine standard of health care for a majority of the state's population. These factors have created a rosy image. But this rosy image won't change Washington. And what happens to medicine there this year happens to the profession throughout the entire nation.

The most effective weapon in combatting socialized medicine is an intelligent and informed public. And the most effective method of reaching these people

is contained in the quotation from Rep. Dorn's letter: "to inform and educate at the grass roots."

Of necessity, this task must fall to the individual physician. Multiply him many times and his power for the good of his own community and his profession becomes an enormous potential.

It is in the support of a grass roots attack that the public relations program of the S. C. Medical Association for 1962 is directed. It contains these points:

1. *Speakers Bureaus* . . . a continuing of this program with emphasis on the establishment of bureaus in all 38 county medical societies.
2. *Radio* . . . production and placement of a series of public service announcements to be placed on all major radio stations throughout the state. Messages will be prepared on both legislative matters and on subjects of particular local community interest.
3. Distribution of current information on the status of the King Bill and its underlying dangers to newspaper editors throughout the state, thus encouraging editorial support of the state medical association.
4. Research and distribution of all materials needed to strengthen the work of individual physicians at the local level.
5. Coverage of the annual convention with distribution of pertinent news material to all principle media.

Make no mistake! *1962 will be a crucial year* for the American Medical profession. It will be a crucial year in California, in Kansas, in Maine and in South Carolina. If the King Bill is passed by Congress no physician, regardless of how fine his personal image may be, will escape the tentacles of socialized medicine. Never before has it been so important to implement and expand the state-wide public relations programs which are, today, bearing fruit in community good will, acceptance and tangible support.

The Month in Washington

Washington, D. C.—The Kennedy Administration and other main supporters of medical care of the aged under social security are preparing to make an all-out effort to push the legislation through Congress in the 1962 session.

Their campaign poses a serious challenge to the medical profession and its allies in the fight against such compulsory government health schemes.

It is too early to evaluate the effect on the legislation of changes in House Democratic leadership and House Ways and Means Committee membership. The White House has been exerting pressure in an effort to have a congressman supporting its views named as a replacement for Rep. Frank Ikard (D., Tex.), who resigned. Ikard opposed proposals to put health care under social security.

Administration officials from President Kennedy down publicly gave the Administration medical care legislation, the King-Anderson bill, top priority for the 1962 session. During the interim after the adjournment of the 1961 session, the Administration held a political roadshow in key cities in an effort to build up public support for the King-Anderson bill and other Administration proposals that did not fare so well in Congress. At a number of the so-called White House Regional Conferences, physicians forcefully expressed the medical profession's opposition to putting health care under social security.

The AFL-CIO geared for a renewed fight for the Administration legislation. A new national organizaton of the elderly has been formed with the main purpose of lobbying for the King-Anderson bill. It is the National Council of Senior Citizens for Health Care Through Social Security. Former Rep. Aime J. Forand (D., R. I.), who sponsored such legislation when he was in Congress, was the leading figure in organizing the group and is national chairman.

On the other side of the fight, there also is a new organization—The American Medical Political Action Committee. It is a non-profit, voluntary, non-partisan, unincorporated committee setup last May with the approval of the A. M. A. Board of Trustees. AMPAC—which functions independently of medical organizations and societies whether at the national, state or local level—was organized to meet "an unmet need—the need of providing the medical profession with an opportunity to assume a more active and effective role in public affairs." The A. M. A. Board of Trustees House of Delegates at Denver, in November urged that all physicians, their wives and interested friends join AMPAC and similar action committees in their states and communities.

Dr. Leonard W. Larson, A. M. A. president, warned the House of Delegates that physicians "are engaged in a historic struggle to preserve our country's unique system of medical care and our stature as a profession." He said both are "seriously threatened" by such legislative proposals as the King-Anderson bill.

Dr. Larson said that the A. M. A. could expect "even more bitter attacks" than those so far from Administration and AFL-CIO spokesmen. He appealed to physicians to support medicine's friends in Congress with money and personal campaign assistance. He noted that AMPAC provides "a national mechanism through which physicians and their families can channel funds for strategic placement where the money will do the most good."

A leading congressional opponent of health care under social security also warned of the seriousness of the fight ahead. Sen. Wallace F. Bennett (R. Utah), a member of the Senate Finance Committee which handles such legislation, told students at Harvard University Medical School that there undoubtedly would be "a determined drive to rush H. R. 4222 (the King-Anderson bill) through the Congress" in 1962.

"The propagandists who are behind the determined drive for a system of socialized medicine have latched on to an emotional appeal in trying to push this legislation through the Congress," Bennett said. "They

have tried to create a public image that the A. M. A. and any individual who opposes this plan is motivated by selfish interests.

"As one who is vigorously opposed to compulsory Federal medical care, I resent the tactics used by those who advocate this system of socialized medicine. There is an answer to this problem of meeting the medical needs of our aged, and I frankly believe that it is being honestly met by our present voluntary health insurance programs and by the cooperative federal-state aid to our needy aged who are incapable of paying their own medical expenses.

"I am opposed to H. R. 4222 or other bills which would open the flood gates to a system of compulsory medical care, directed first to our aged, but which, once instituted, would surely by political pressure be expanded to all of our population. The battle over this legislation in this next Congress is bound to be hectic and monumental. It is a battle we can't afford to lose."

National Whirligig

BY J. F. terHORST

"I have heard about some new organization of elderly persons that is in favor of medical care for the aged under Social Security," writes C. D. of Long Beach, Calif. "Since I favor that, do you know anything about this group?"

A letter on the same subject comes from Mrs. R. C. of Flint, Mich., who wants to know "if Mr. Kennedy has any ambition to push this aid scheme through Congress next year."

* * *

"Getting Up Steam" The answer to both writers is "yes." The newly organized National Council of Senior Citizens for Health Care Through Social Security is just getting up steam. It promises to be the biggest citizen lobby for a single bill on Capitol Hill in many a year.

It will be working with the White House, in line with President Kennedy's letter last August to Senator Pat McNamara (D., Mich.). "I intend to recommend that this legislation be given the highest priority at the next session of Congress," Mr. Kennedy said.

Thus the stage is set for what will probably be the noisiest, most pressurized debate on a domestic issue before Congress when it returns in January.

If the country's aging citizens actually do launch a campaign for the bill, the American Medical Association and conservative lawmakers will be taxed to the utmost to best the Administration request.

* * *

How Organized Here's how the new lobby came into being and how it hopes to win:

The Senior Citizens council was conceived during the White House Conference on Aging early in January by a group of pro-Kennedy persons headed by former Rep. Aime J. Forand (D., R. I.), chief sponsor of social security health care in previous years.

In midsummer Forand agreed to become its national chairman. Modest offices have been set up in Washington at 200 C Street, S. E. Its governing body is an 18-member board comprising doctors, welfare officials, university gerontologists, leaders of Golden Ring clubs and key officials of the Senior Citizens For Kennedy group.

The purpose, according to Forand, is to "weld Senior Citizens' organizations and millions of interested individuals from all over the country into one strong and effective voice in Washington." The immediate goal is to "secure legislation providing health care for the aged through Social Security."

* * *

Members in Millions A potential membership of millions seems no idle boast. There are 16.5 million persons over 65 years of age in the country. There are an estimated 7,000 senior citizens and Golden Ring clubs as well as many retiree organizations sponsored by labor unions.

Before Congress returns, Forand is concentrating on educational work through mailings and talks before senior citizens groups on the differences between the King-Anderson bill for Social Security aid and the existing Kerr-Mills law. The latter provides health care on a limited basis.

After Congress returns, the national council hopes to inspire its members to deluge their individual senators and congressmen with letters and heavy home-front pressure to back the King-Anderson bill.

* * *

Medical Marches If necessary, the council may organize "marches" on Washington so that senior voters can buttonhole their lawmakers in person.

This reporter understands that Mr. Kennedy and Health-Education-Welfare Secretary Abraham Ribicoff are prepared to lend all possible assistance to the "grass roots" campaign in order to win congressional passage of the medicare principle.

Reports are that the AMA and insurance groups are considering a rival association of senior citizens who oppose social security health care.

Should the two groups bump into each other on Capitol Hill, the Red Cross may have to set up first aid stations.

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Medical Card—Persons laboring under recent infections (contracted in an unguarded hour) the injudicious use of mercury, or who have brought on themselves by a secret destructive habit, a train of melancholy evils, will meet with efficient, safe and efficacious treatment by calling at 41 Queen Street.

Charleston Courier
Feb. 2, 1838

FIFTY YEARS A DOCTOR
Reminiscences

By J. L. Anderson, M. D.
Greenville, S. C.

A pleasant pastime for one as he grows older is to think again of the satisfying experiences of his earlier years. I wish to record some of those experiences, thinking that perhaps my younger colleagues might find them interesting.

I graduated from Davidson College in 1903. Then, I taught school for one year before beginning the study of medicine at the University of Maryland. I received my M. D. Degree in 1908. Both my internship and a year as assistant medical resident were in the University Hospital in Baltimore.

As a resident in medicine, I soon realized that my first love in clinical practice would be internal medicine. However, for some years after I located in Greenville, I did a general practice.

Definitive diagnosis intrigued me. It seemed to me to be the most important element of medical treatment. To arrive at a tenable diagnosis, I soon learned one must obtain a correct history of the case and then make a thorough physical examination. After that, one could intelligently order the indicated laboratory studies and x-ray examinations. Finally, then one was in position to fit the findings into a logical clinical picture.

As the years of practice pass in review in my memory, I realize again that I had to "unlearn", or alter much that I had come to believe was sound practice. Medical science and my knowledge of it has been progressive.

I recall so well how in the earlier days of my practice, I treated postpartal infection by intrauterine douching and at times, by curettement. An article by a Dr. Watkins, which I read, called attention to the fact that in the infected uterus nature built up a protective barrier of leucocytes. To disturb this barrier, was to invite a spread of the infection, even to the extent of septicemia. Dr. Watkins mentioned only one reason for curettement, namely, to control severe hemorrhage. I adopted Dr. Watkins' advice with considerable satisfaction to myself and to my patients.

During the First World War, I served as a member of the Medical Advisory Board of upper South Carolina. My colleagues, who served with me, were: Drs. L. O. Mauldin, George Tyler, Charles H. Fair, and Charles Mobley. Dr. Mobley then lived in Rock Hill. He now lives in Orangeburg.

The duty of this Board was to determine whether or not draftees referred to it by the various county boards were fit for military service. We examined 30 to 40 men each week. The examining room was in the former post office building, now the Greenville City Hall. My task was to examine hearts and lungs. Our work was made the more difficult by the criticism of our rulings in some cases by dissident and prominent families. My military rank was that of major. This I continued to hold for about ten years after the war.

My mind turns to my colleague, Dr. Robert C. Bruce, who was councillor for the fourth medical district during and after the war years. He was the "trouble shooter" at all times. We had at times in the Greenville County Society and in the City Hospital staff serious discord. Bob Bruce was listened to as an arbiter. By temperament, and by training and experience, he was well qualified to evaluate the matters in dispute, and to settle them with judicial calm. He was a dedicated physician, a loyal friend, a devoted husband and father, and a patriotic citizen.

As a member of the staff of City Hospital, now the Greenville General Hospital, I had the opportunity to treat many cases of heart disease, pneumonia, and typhoid fever. Our available drugs were of little value in these diseases. During the summer season, the hospital was filled to overflowing with typhoid cases. We fed our patients with liquids and soft diets, and with much buttermilk. This was a radical departure from the former practice of denying all solid or semisolid foods to typhoid cases. Although we did have some instances of bowel hemorrhage and an occasional intestinal perforation, our cases on the whole, did much better than they had under the starvation plan of treatment. At that time, we had no fluids for intravenous administration and no blood for transfusion.

Certain cases stand out vividly in my memory. One such was a woman in her early seventies, who had pernicious anemia. The diagnosis was made by blood examination.

When I first saw her, she was unable to retain food, and she had severe diarrhea, or dysentery. Remember we had no blood transfusion and no knowledge of the curative value of liver in cases of pernicious anemia.

It was in 1936. I picked up a copy of the Medical Clinics of North America, and saw there an article by Minot and Murphy, who reported their results with liver in the treatment of pernicious anemia. I had a broth made of calves' liver and had it fed, a teaspoonful at a time, to the patient. Soon she was able to drink the broth from a cup. Liver given in this manner, relieved her symptoms and she lived nearly ten years after that serious episode.

Then there was the case of my own son, who was twelve years of age at the time. He developed enlargement of the posterior cervical glands, superficial ulcers of the soft palate, a high fever, and aches and pains. His blood examination showed a leucocytosis of about 14,000, and an increase in monocytes. The general physical examination was essentially negative except for the posterior cervical lymph adenitis. The spleen was not palpable.

Dr. R. M. Pollitzer, who had been his pediatrician, was called in consultation. The case was obscure to us. We sent a full report of all the clinical and laboratory data to Dr. George Minot of Boston, to Dr. Tom Sprunt of Johns Hopkins, and to Dr. Sydenstricker of Augusta. Each of these eminent colleagues promptly wired us his opinion. Each gave as his diagnosis, infectious mononucleosis, and each stated that recovery would occur.

Our fears that the condition was agranulocytosis, a condition just then coming into prominence, and one considered to be malignant, were groundless.

In 1935, Dr. C. B. Earle did a radical breast amputation because of cancer in a young woman. X-ray exposure was given postoperatively. That was a routine treatment following operation at that time. The patient had recurrent local metastases for a number of years, each of which was excised as it appeared. She was also treated with the male sex hormone for about 18 years. Some two years after the patient had moved to Charlotte, I was called to see her in consultation. She had developed another metastases in the chest wall. It was decided to remove it surgically. When the chest cavity was opened, metastases were seen on the pericardium and on the pleura. The case was considered to be hopeless. However, it was decided to remove all tissue damaged by the x-rays, and to skin graft the wound. Later bilateral oophorectomy was done. That was four years ago. She continues to be in good health.

The climax of my experience in internal medical diagnosis occurred in 1941. Dr. Reginald Fitz of Boston had published in the *Recorder* the case history of an obscure case condition in his experience. He was coming to Columbia to speak and to present this case for discussion. He offered a bottle of Caldwell's rum as a prize to the local doctor who would make the first diagnosis from the protocol. The woman, she was a woman about 41 years of age, had been hospitalized and carefully studied in two different Boston hospitals, after she had been ill already for 13 months. As one might expect the protocol was quite detailed and voluminous.

Several colleagues and I drove down to Columbia to hear Dr. Fritz and to hear in particular a discussion of this particular case. When it was presented, there was considerable discussion, before I spoke. Suggested diagnoses were carcinoma of the liver, amoebic abscess of the liver, and abscess of the liver, not caused by amoeba.

I recalled the fact that there must have been involvement of the liver, but that it could not have been cancer, because of the duration of disease, the mild anemia, the mild jaundice, and the high leucocyte count.

It probably was not amoebic abscess of the liver because the leucocytosis would seem to rule it out. It was my contention that the case fulfilled each of Cecil's requirements for non-amoebic abscess of the liver, namely, "malaise, intermittent fever, chills, pain in the right upper quadrant, with enlargement and tenderness of the liver, leucocytosis and slight jaundice."

My diagnosis was correct as had been proven by autopsy, and I was awarded the bottle of very excellent rum.

During my medical career, diphtheria antitoxin, tetanus antitoxin, insulin, antimeningococcic serum and Ehrlich's 606, in addition to the biochemicals and the antibiotics have all been discovered, introduced to the profession, and used by it in a most dramatic extension of its power to prolong life. However, after all is said, it is still my contention that correct diagnosis is the foundation stone of all appropriate treatment.

COULD YOU AFFORD TO RETIRE?

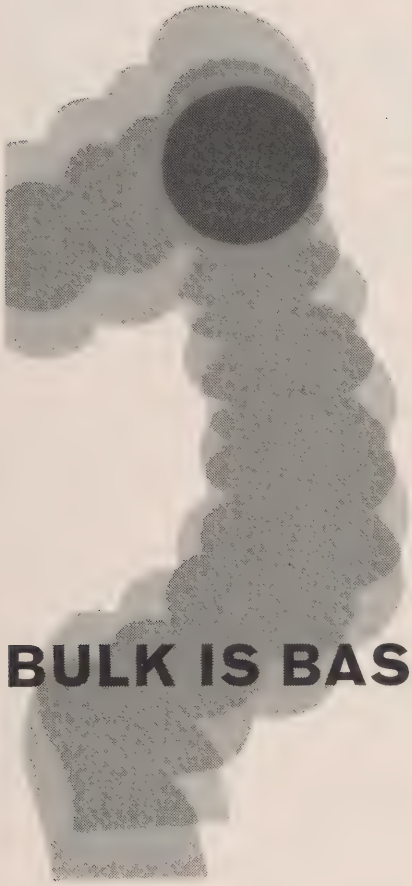
DONALD G. KILGORE, JR., M. D.
Greenville, S. C.

One day all of us will face the question, "Should I retire?" The younger doctor might say, "I am just starting out in practice. Why should I think of retirement?" Even if your retirement day is 30 or 40 years away, a little organizing will keep you from realizing when that day comes that you cannot retire.

Many of you may say, "I don't plan to retire, I am going to die in harness." This is a very popular attitude, and one that I personally endorse. However, sometimes the decision to retire is not made by us, but is dictated by sickness, accident, or other circumstances. A serious illness or incapacitation might give you the unhappy choice of continuing full practice under conditions which would endanger your life, or retiring or limiting your practice on a poor fraction of your former income. If adequate retirement income were available, this choice would be very simple. Even assuming that you are never required to retire because of health or accident, sooner or later you will probably want to limit your practice without too drastic a cut in your income. What then are some of the available methods to provide for retirement income?

First of all is the time honored method through savings accounts and stocks and bonds. Regular systematic savings in banks and building and loan associations is an excellent way to build up a nest egg for retirement. However, even at 4% interest per year, it takes a long time to build up a retirement nest egg. Savings bonds suffer the same disadvantages. Investments in stocks, either individually or through mutual funds, may yield a very handsome return for your money. Some doctors are quite successful in providing for their retirement income this way. However, most of us do not have the luck, the investment acumen, or the necessary time to guarantee that this method will work successfully for us.

Another method of savings for retirement is a life insurance annuity policy. An excellent plan has been offered recently by the South Carolina Medical Association. This has many advantages. First of all your money is quite safe. While your investment won't rise in value like a good common stock, it won't drop like a bad one. Secondly, the insurance policy is an incentive to regular savings. You might become careless about a self-imposed stock purchase schedule, but you are unlikely to let an insurance policy lapse. Finally, the interest earned by your cash values builds up and compounds tax free. It will be taxed only as you draw annuity payments. After you retire, you are likely to be in a much lower tax bracket. Because of the way annuity income is treated, some of it may never be taxed at all.





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1. Sollmann, T.: A Manual of Pharmacology and Its Applications to Therapeutics and Toxicology, ed. 8, Philadelphia, W. B. Saunders Company, 1957, p. 206.

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Research in the Service of Medicine

However, this annuity policy has certain disadvantages. First of all it pays off only in a fixed number of dollars. When your retirement time comes in 20 or 25 years the income that would be ample today might be totally inadequate at that time. Many of you may remember the advertisements of the Phoenix Mutual Insurance Company back in the late 30's and early 40's about a glowing description of a couple who retired in Florida on $100 a month. The Phoenix Mutual uses similar advertisements today. There has been only one minor change. *They now glowingly describe retirement on $300 a month.* The second disadvantage of an annuity is that, the rate of interest, even in this excellent policy of the South Carolina Medical Association, is only 3½%. If you can force yourself to consistent savings, you can do much better in many building and loan associations or in bonds.

All of these methods have one fundamental glaring disadvantage. *They utilize money on which you must pay income tax of 25 to 50% depending upon the bracket you are in.* Is it possible to avoid this crippling tax? Several possibilities have presented themselves in recent years.

One possibility is the Jenkins-Keogh bill. This bill allows a maximum of $2500 a year to be set aside for retirement purposes before any income taxes are levied. This bill would be ideal if it were enacted. Although it has been introduced into every session of Congress since 1951, it has never passed both houses. This year it was passed by the House and approved by the Senate Finance Committee, but it still did not reach the Senate floor. The Senate Finance Committee mutilated it considerably and destroyed many of its benefits. Most people believe that it will never pass because President Kennedy and the Treasury Department are both opposed to it.

A more likely possibility is the passage of a professional association act in South Carolina. Such acts have been passed recently in approximately fifteen states, including our neighboring states of Georgia, Florida, and Alabama. In Georgia only two persons are needed to form a professional association. In Florida a single professional person may form such an association if he so desires. These associations allow doctors to pay themselves salaries and bonuses which naturally are taxable. But they may also set aside tax free any amount they desire for their pension plan. This amount must be within the regulations of the Internal Revenue Service which provides that no pension may amount to more than 10% of the first $4,800 of the person's average yearly preretirement income plus 40% of the excess over $4,800.

Some doctors may ask, "Does this permit the corporate practice of medicine?" In both Georgia and Florida professional association acts it is clearly stated that no one may be a member of such a professional association except a person who is duly licensed to practice this profession in the state. This means that hospitals or corporations could not form a professional association. South Dakota states in addition that all such associations must obtain a certificate from the State Board of Medical Examiners. This certificate may be suspended or revoked if the association failed to discharge any officer or employee whose license to practice medicine is suspended or revoked.

Because of the doubtful possibilities of the Keogh bill becoming a law, it would appear that doctors and members of other professions would benefit greatly by having such a law in South Carolina. It has numerous advantages and almost no disadvantages. It would end the discrimination against the independent professional man of the opportunity to receive a pension that an employee of a corporation now enjoys. We should join with the dentists, lawyers, engineers, accountants, and other professional men in urging the passage of such a law in this state.

WANTED: Male psychiatrist under age of 50 years. Board certified or Board eligible to head established private psychiatric clinic in city 75,000. Graduate American school of medicine. Salary: $18,000-$20,000, depending upon qualifications and experience, plus liberal fringe benefits. Incentive plan permits additional earnings of $5,000 annually. Address Box 1, in care of this Journal.

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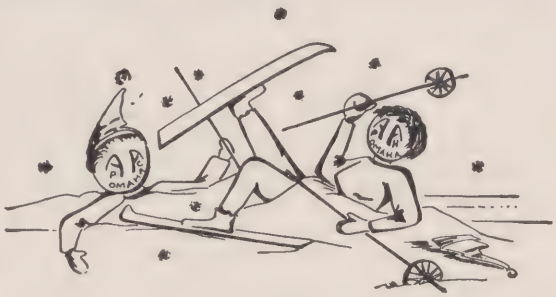
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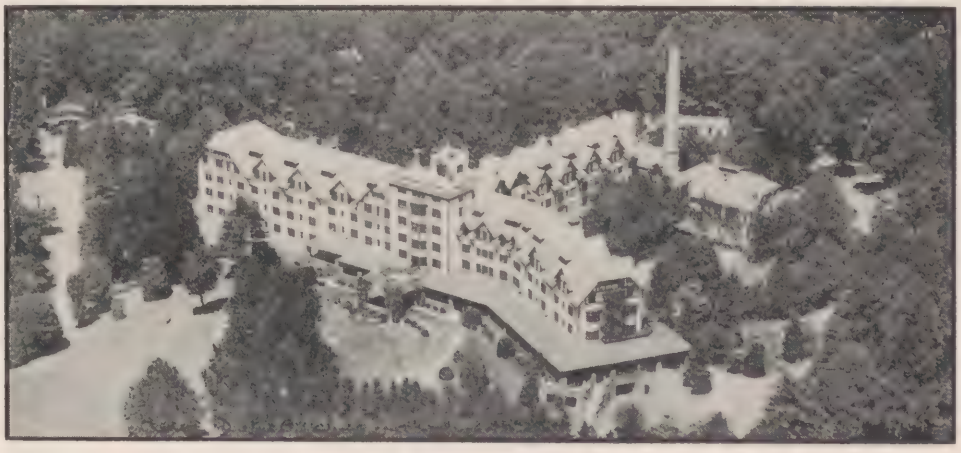
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Thank each South Carolina Physician
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May each of you have a
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You and your patients

should read

the story beginning on page 69—

December, Reader's Digest.

It deals tersely and thoughtfully

with major issues

raised in the investigation of

the prescription drug

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This message is brought to you on behalf
of the producers of prescription drugs.
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1411 K. Street, N.W., Washington, D.C.



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, *fast!*

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

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This was demonstrated by Kestler in a controlled study: average time for full recovery was 11.5 days with Soma, 41 days without Soma. (J.A.M.A. **172**:2039, April 30, 1960.)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets.
USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

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(carisoprodol, Wallace)

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"The first prescription I ever wrote was for 'Empirin' with Codeine...



and it is still my stand-by for pain relief today."

PICTURE THE YOUNG DOCTOR with his first private patient, about thirty-five years ago. This is the moment, after years of study and guidance in classroom and at hospital bedside, when he assumes the full weight of responsibility for the well-being of his patient. He makes his diagnosis. The patient is in considerable pain, and his first concern is to relieve this discomfort. He writes a prescription for a new analgesic, a convenient drug combination that he believes will be of help. This patient (and many others to follow) finds gratifying relief, and the physician continues to rely upon this medication as the years go by.

Could this have been you in the 1920's? That was when 'Empirin' Compound with Codeine first came into general use (although plain 'Empirin' Compound has been well-known since the influenza epidemic of 1918). Satisfaction through the years has prompted doctors everywhere to depend on 'Empirin' with Codeine for relief of most all degrees of pain. For with this well-tolerated, reliable analgesic combination you can be sure of results, and feel secure in the fact that the liability of addiction is negligible.

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'EMPIRIN' COMPOUND with CODEINE PHOSPHATE*

Acetophenetidin, gr. 2½
Acetylsalicylic Acid, gr. 3½
Caffeine, gr. ½

Remember there are now four strengths available...

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No. 1 – gr. ⅛
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No. 3 – gr. ½
No. 4 – gr. 1

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In intestinal "grippe"

prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
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EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

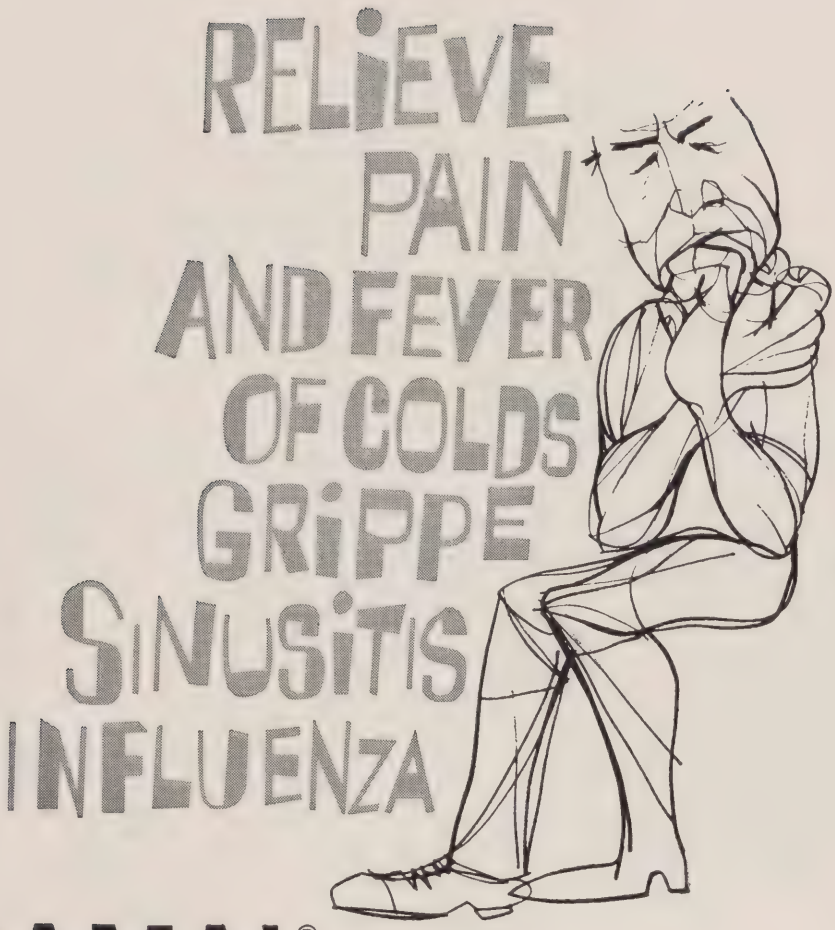
Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

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Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.





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(Analgesic-Antipyretic-Sedative)

- **Relieves pain and tension**
- **Reduces fever**
- **Stops excessive nasal secretions**
- **Without unwanted diaphoresis**

Hasamal, with mild sedation, effectively relieves malaise and discomfort associated with acute infectious disease, such as colds, grippe, sinusitis, tonsillitis, and for earache, headache, and pain of arthritis, neuritis, neuralgia, dysmenorrhea, etc.

Where pain of increased intensity occurs, HASACODE, containing ¼ gr. codeine phosphate, and HASACODE "STRONG," containing ½ gr. codeine phosphate, provide prompt, effective relief.

Composition: HASAMAL: Each tablet or capsule contains: Acetylsalicylic acid, 2½ gr., acetophenetidin, 2½ gr., phenobarbital, ¼ gr., and hyoscyamus alkaloids, .0337 mg. HASACODE combines the same formula as Hasamal with ¼ gr. codeine phosphate, and HASACODE "STRONG" ½ gr. codeine phosphate.

Dosage: Hasamal: One or two tablets or capsules every 3 to 4 hours. **Hasacode:** One or two tablets every 3 or 4 hours; not more than 8 tablets should be taken in 24 hours. **Warning:** Do not use in patients with glaucoma or in elderly patients with prostatic hypertrophy.

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Richmond, Virginia



Emotional control regained . . . a family restored . . . thanks to a physician and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances, because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the reassuring fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

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posed by professional models

'THORAZINE' PRESCRIBING INFORMATION

Because of its pronounced calming effect, 'Thorazine' is an outstanding agent for patients with mental and emotional disturbances, particularly those with symptoms of agitation and hyperactivity. In severe cases, initial use of intramuscular administration may be desirable to control symptoms promptly.

Before prescribing 'Thorazine' for other indications than those given below, the physician should be familiar with the dosage, side effects, cautions and contraindications for such uses. This information is available in the *Thorazine® Reference Manual* and *Physicians' Desk Reference,* and from your SK&F representative or your pharmacist.

ADMINISTRATION AND DOSAGE

Dosage should always be adjusted to the response of the individual and according to the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become troublesome. In emaciated or senile patients, dosage increases should be made more gradually than in other patients.

ADULT DOSAGE

Mental and Emotional Disturbances (e.g., agitation, excitement, or anxiety)—*Starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg. to 50 mg. daily, at semiweekly intervals, until maximum clinical response is achieved. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but some patients may require substantially higher dosages. Discharged mental patients, for example, may require daily dosages as high as 800 mg. *Starting intramuscular dose* is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d.

Alcoholism—Severely agitated patients: *Starting intramuscular dose* is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg. t.i.d. **Agitated but manageable patients:** *Starting oral dose* is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, *starting oral dose* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

CHILDREN'S DOSAGE

For Behavior Disorders—*Oral dosage* is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). *Rectal dosage* is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). *Intramuscular dosage* is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day; in children 5-12 years (or 50-100 lbs.)—not over 75 mg./day except in extreme unmanageable cases. In severe cases, higher dosages than those recommended above may be necessary. In such cases, 50-100 mg. daily has been used and, in older children, as much as 200 mg. daily or more may be required.

IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward because of possible hypotensive effects. The injection should be given *slowly, deep* into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery.

'Thorazine' Injection should not be mixed with other agents in the syringe. Because contact dermatitis has been reported with 'Thorazine', nurses or others giving frequent injections should avoid getting the solution on hands or clothing. 'Thorazine' Injection should be protected from light, since exposure may cause discoloration. Slight yellowish discoloration will not alter potency or efficacy. If markedly discolored, the solution should be discarded.

SIDE EFFECTS

The drowsiness caused by 'Thorazine' is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine.

Other side effects reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses.

Some patients have an increased appetite and gain weight, but usually reach a plateau beyond which they do not gain.

CAUTIONS

Jaundice: The over-all incidence of jaundice due to 'Thorazine' has been low—regardless of indication, dosage, or mode of administration. It appears to be related to duration of therapy. Few cases have occurred in less than one week or after six weeks. The jaundice that has occurred mimics the obstructive type, is without parenchymal damage, and is usually promptly reversible upon the withdrawal of 'Thorazine'. Although the mechanism is not clearly understood, most investigators conclude that it is a sensitivity reaction in susceptible individuals.

There is no conclusive evidence to indicate that pre-existing liver disease makes the patient more susceptible to jaundice. (Patients with known alcoholic cirrhosis have been treated with 'Thorazine' without further alteration of liver function.) Nevertheless, 'Thorazine' should be used with due consideration in a patient with liver disease.

If a patient on 'Thorazine' suddenly develops fever with grippe-like symptoms, his serum should be tested for increased bilirubin or his urine for the presence of bile. If any of these tests are positive, 'Thorazine' should be discontinued.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

Agranulocytosis: Agranulocytosis, although rare, has been reported. Patients should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted.

Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

A moderate suppression of total white blood cells, sometimes observed in patients on 'Thorazine' therapy, is not an indication for discontinuing 'Thorazine' unless accompanied by other symptoms.

Potentiation: 'Thorazine' prolongs and intensifies the action of many central nervous system depressants such as anesthetics, barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ¼ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.)

Hypotensive Effect: Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If a vasoconstrictor is required, 'Levophed' and 'Neo-Synephrine'★ are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Antiemetic Effect: The antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

Dermatological Reactions: Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some appear to be due to photosensitivity, and patients on 'Thorazine' should avoid undue exposure to the summer sun.

Neuromuscular (Extrapyramidal) Reactions: With very high doses of 'Thorazine', as frequently used in psychiatric cases over long periods, a few patients have exhibited neuromuscular (extrapyramidal) reactions which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug temporarily withdrawn. These reactions can also be controlled by the concomitant administration of an anti-parkinsonism agent (see *Physicians' Desk Reference*). Depending on the severity of the symptoms, suitable supportive measures such as maintaining a clear airway and adequate hydration should be employed. When 'Thorazine' is reinstituted, it should be at a lower dosage.

Lactation: Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

CONTRAINDICATIONS

'Thorazine' is contraindicated in comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.) and also in patients under the influence of large amounts of barbiturates or narcotics.

SUPPLIED

Tablets, 10 mg., 25 mg., 50 mg. and 100 mg., in bottles of 50, 500 and 5000; 200 mg., for use in mental hospitals, in bottles of 500 and 5000. (Each tablet contains 10 mg., 25 mg., 50 mg., 100 mg., or 200 mg. of chlorpromazine hydrochloride.)

Spansule® capsules, 30 mg., 75 mg., 150 mg. and 200 mg., in bottles of 30, 250 and 1500; also 300 mg., in bottles of 30 and 1500. (Each 'Spansule' capsule contains 30 mg., 75 mg., 150 mg., 200 mg., or 300 mg. of chlorpromazine hydrochloride.)

Ampuls, 1 cc. and 2 cc. (25 mg./cc.), in boxes of 6, 100 and 500. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 6 mg. of sodium chloride.)

Multiple-dose Vials, 10 cc. (25 mg./cc.), in boxes of 1, 20 and 100. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 1 mg. of sodium chloride; 2% benzyl alcohol as preservative.)

Syrup, 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc. contains 10 mg. of chlorpromazine hydrochloride.)

Suppositories, 25 mg. and 100 mg., in boxes of 6. (Each suppository contains 25 mg. or 100 mg. of chlorpromazine; glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated cocoanut oil fatty acids, hydrogenated palm kernel oil fatty acids, lecithin.)

Concentrate (for hospital use), 30 mg./cc., in 4 fl. oz. bottles, in cartons of 12 and 36, and in gallon bottles. (Each cc. contains 30 mg. of chlorpromazine hydrochloride.)

★'Levophed' and 'Neo-Synephrine' are the trademarks (Reg. U.S. Pat. Off.) of Winthrop Laboratories for its brands of levarterenol and phenylephrine respectively.

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NICOZOL COMPLEX is a cerebral stimulant-tonic and dietary supplement intended for geriatric use. Improves mental and physical well-being. Improves protein and calcium metabolism. Indicated during convalescence, also as a preventive agent in common degenerative changes.

Dosage:

1 teaspoonful (5 cc) 3 times a day, preferably before meals. Female patients should follow each 21-day course with a 7-day rest interval.

Supply:

NICOZOL COMPLEX is available as a pleasant-tasting elixir. Popularly priced. Bottles of 1 pint and 1 gallon.

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Each 15 cc (3 teaspoonfuls) contains:

Pentylenetetrazol	150 mg.
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Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thiamine Hydrochloride	6 mg.
Riboflavin	3 mg.
Pyridoxine Hydrochloride	6 mg.
Vitamin B-12	2 mcg.
Folic Acid	0.33 mg.
Panthenol	5 mg.
Choline Bitartrate	20 mg.
Inositol	15 mg.
1-Lysine Monohydrochloride	100 mg.
Vitamin E (a-Tocopherol Acetate)	3 mg.
Iron (as Ferric Pyrophosphate)	15 mg.
Trace Minerals as: Iodine 0.05 mg., Magnesium 2 mg., Manganese 1 mg., Cobalt 0.1 mg., Zinc 1 mg.	

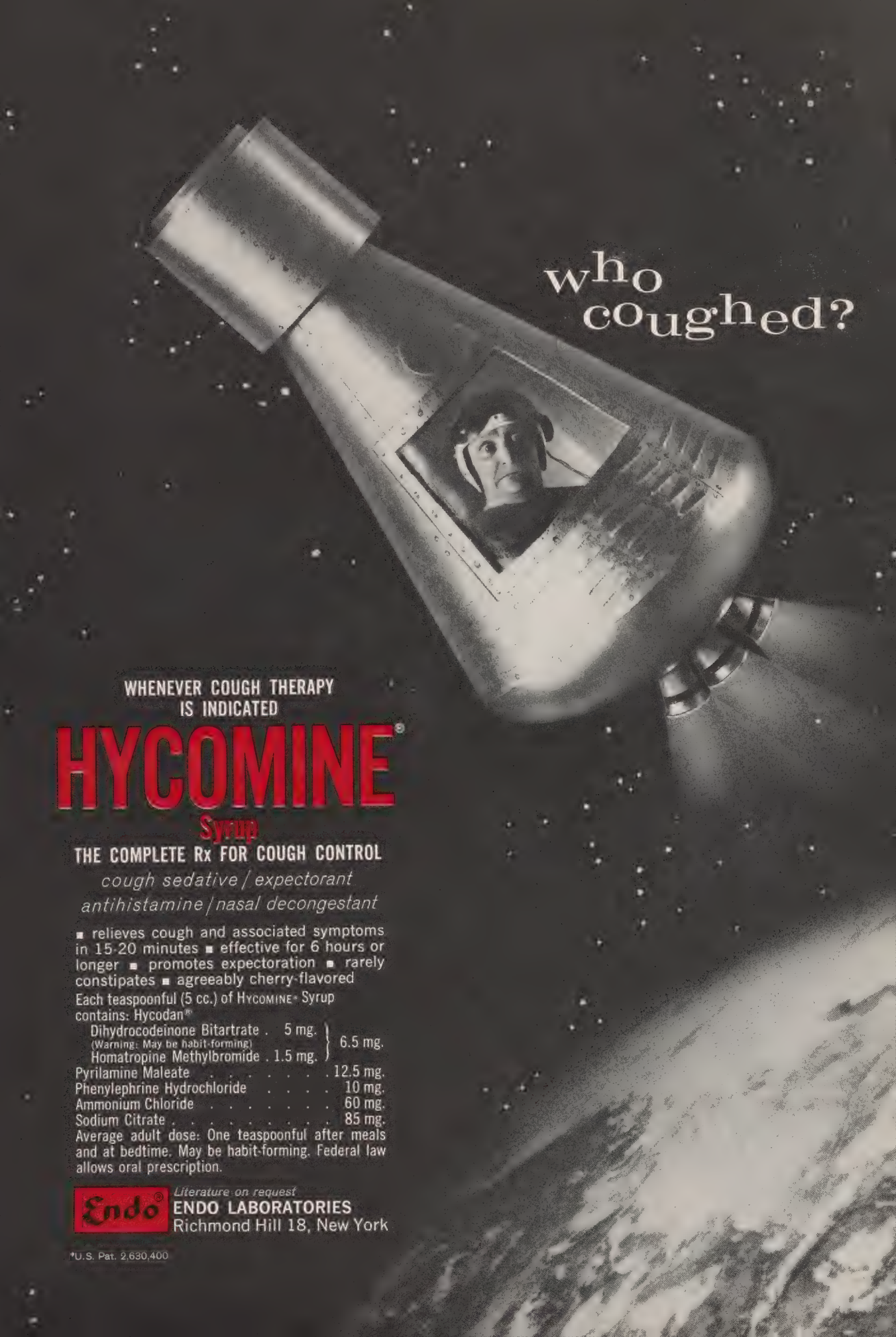
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Syrup

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cough sedative / expectorant
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■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains: Hycodan®

Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law allows oral prescription.

Literature on request
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Richmond Hill 18, New York

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16 mg. in bottles of 50

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MEDROL MEDULES*
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40 mg./cc. in 1 cc. and 5 cc. vials
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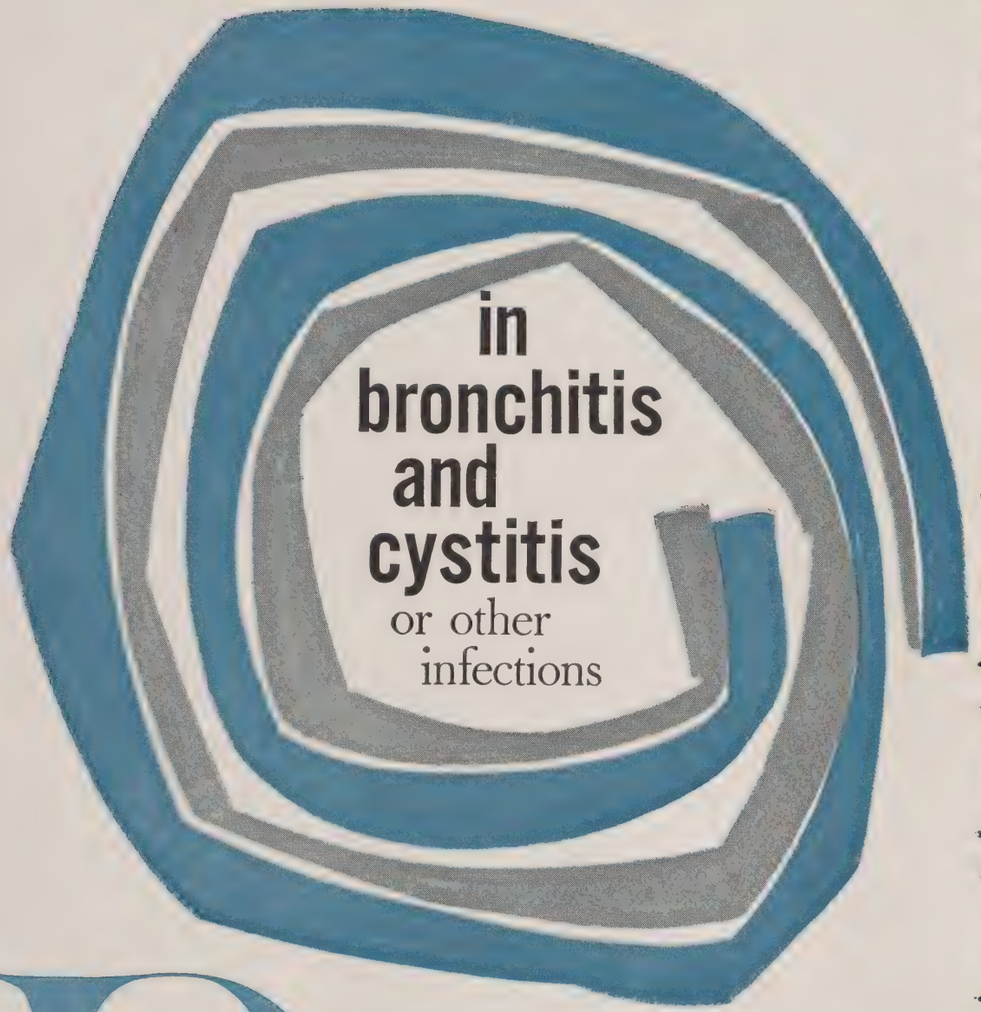
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CAPSULES, 150 mg., 75 mg. *Dosage:* Average infections—150 mg. four times daily. Severe infections—Initial dose of 300 mg., then 150 mg. every six hours.

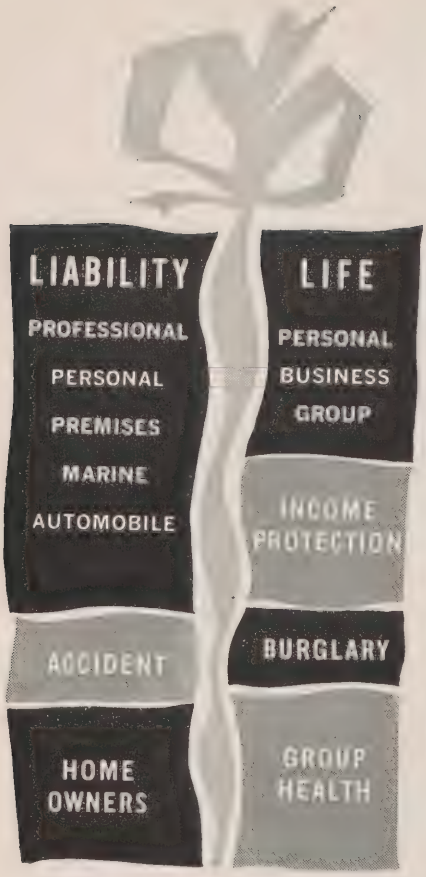
PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. *Dosage:* 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into four doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored). *Dosage:* 3 to 6 mg. per pound body weight per day—divided into four doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics, and demands that the patient be kept under constant observation.

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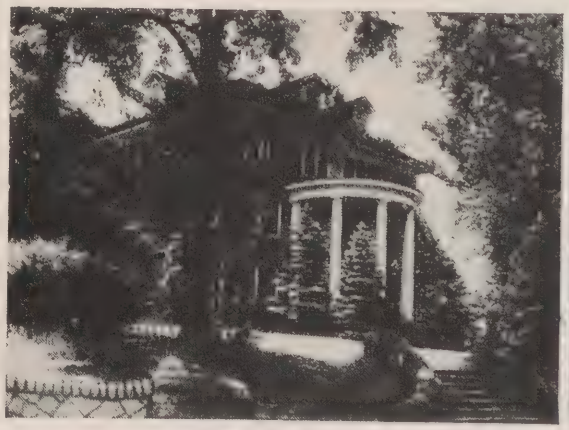
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Recent medical literature[1-27]—adding to an already massive bibliography—continues to document the effectiveness of well-tolerated Terramycin in pediatric, respiratory, and other infections.

Recent bibliography: 1. A.M.A. Council on Drugs, New and Nonofficial Drugs 1961, Philadelphia, Lippincott, 1961, pp. 142-147. **2.** Beckman, H.: The Year Book of Drug Therapy, Chicago, Yr. Bk. Pub., 1961, p. 271. **3.** Eastman, N. J., and Hellman, L. M.: Williams Obstetrics, ed. 12, New York, Appleton-Century-Crofts, 1961, pp. 845-1035. **4.** Keefer, C. S., in Modell, W.: Drugs of Choice 1960-1961, St. Louis, Mosby, 1960, pp. 141, 146, 147. **5.** Huang, N. N.: J. Pediat. 59:512, 1961. **6.** Smith, R. C. F.: Brit. J. Clin. Practice 15:345, 1961. **7.** Asay, L. D., and Koch, R.: New England J. Med. 262:1062, 1960. **8.** Berry, D. G., et al.: Lancet 1:137, 1960. **9.** Osol, A., et al.: The Dispensatory of the United States of America, ed. 25, Philadelphia, Lippincott, 1960, pp. 953, 1556. **10.** Adams, A. R. D.: Brit. M. J. 1:1639, 1960. **11.** Jung, R. C., and Carrera, G. M.: Dis. Colon & Rectum 3:313, 1960. **12.** De Lamater, J. N.: Am. J. Gastroenterol. 34:130, 1960. **13.** Stewart, W. H., et al., in Kelley, V. C.: Brenneman-McQuarrie-Kelley Practice of Pediatrics, Maryland, Prior, 1960, vol. II, chap. 5, p. 19. **14.** Wellman, W. E., and Herrell, W. E., in Kelley, V. C.: Brenneman-McQuarrie-Kelley Practice of Pediatrics, Maryland, Prior, 1960, vol. I, chap. 44, p. 13. **15.** Wenckert, A., and Robertson, B.: Acta chir. scandinav. 120:79, 1960. **16.** Alstead, S.: Dilling's Clinical Pharmacology, ed. 20, London, Cassell, 1960, p. 462. **17.** Grover, F. W.: Texas J. Med. 57:355, 1961. **18.** Gardiner, W. P., and Gomila, R. R., Jr.: Scientific Exhibit, Venereal Disease Seminar, U. S. Public Health Service, Feb. 28-Mar. 3, 1961. **19.** Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, 1961. **20.** Nathan, L. A.: Scientific Exhibit, 15th Clinical Meet., A.M.A., Denver, Col., Nov. 26-30, 1961. **21.** Ullman, A.: Delaware M. J. 32:97, 1960. **22.** Lamphier, T. A.: Scientific Exhibit, New York State M. Soc. Meet., New York, May 7-13, 1960. **23.** Freier, A.: Paper presented at Michigan Soc. Obst. & Gynec., Detroit, May 3, 1961. **24.** Logan, K. M.: Scientific Exhibit, Ann. Meet., Ohio Acad. Gen. Practice, Cincinnati, Sept. 13-14, 1961. **25.** Altemeier, W. A., and Wulsin, J. H. (A.M.A. Council on Drugs Report): J.A.M.A. 173:527, 1960. **26.** Krol, W. J.: J. Abdom. Surg. 3:78, 1961. **27.** Potempa, J.: Med. Klin. 56:352, 1961.

In Brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated. For complete dosage, administration, and precaution information, read package insert before using.

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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., **et al.**: Diabetes 7:398, 1958.

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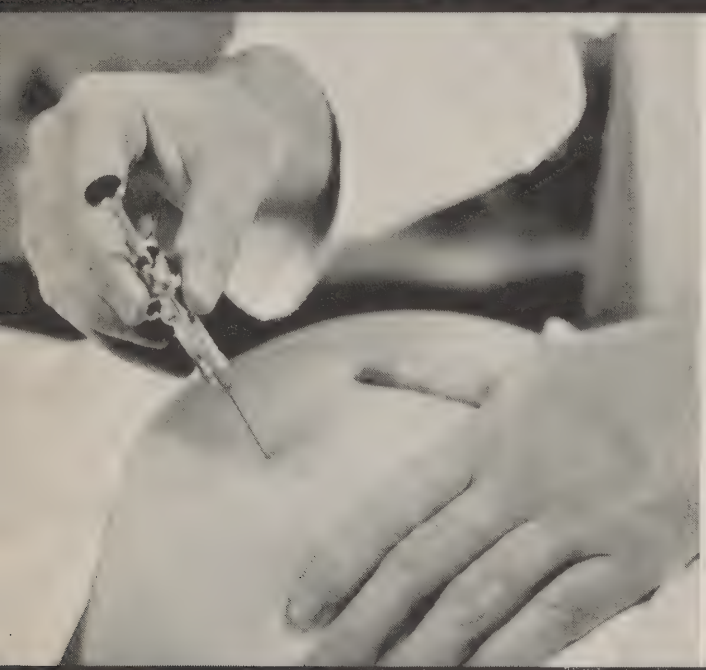
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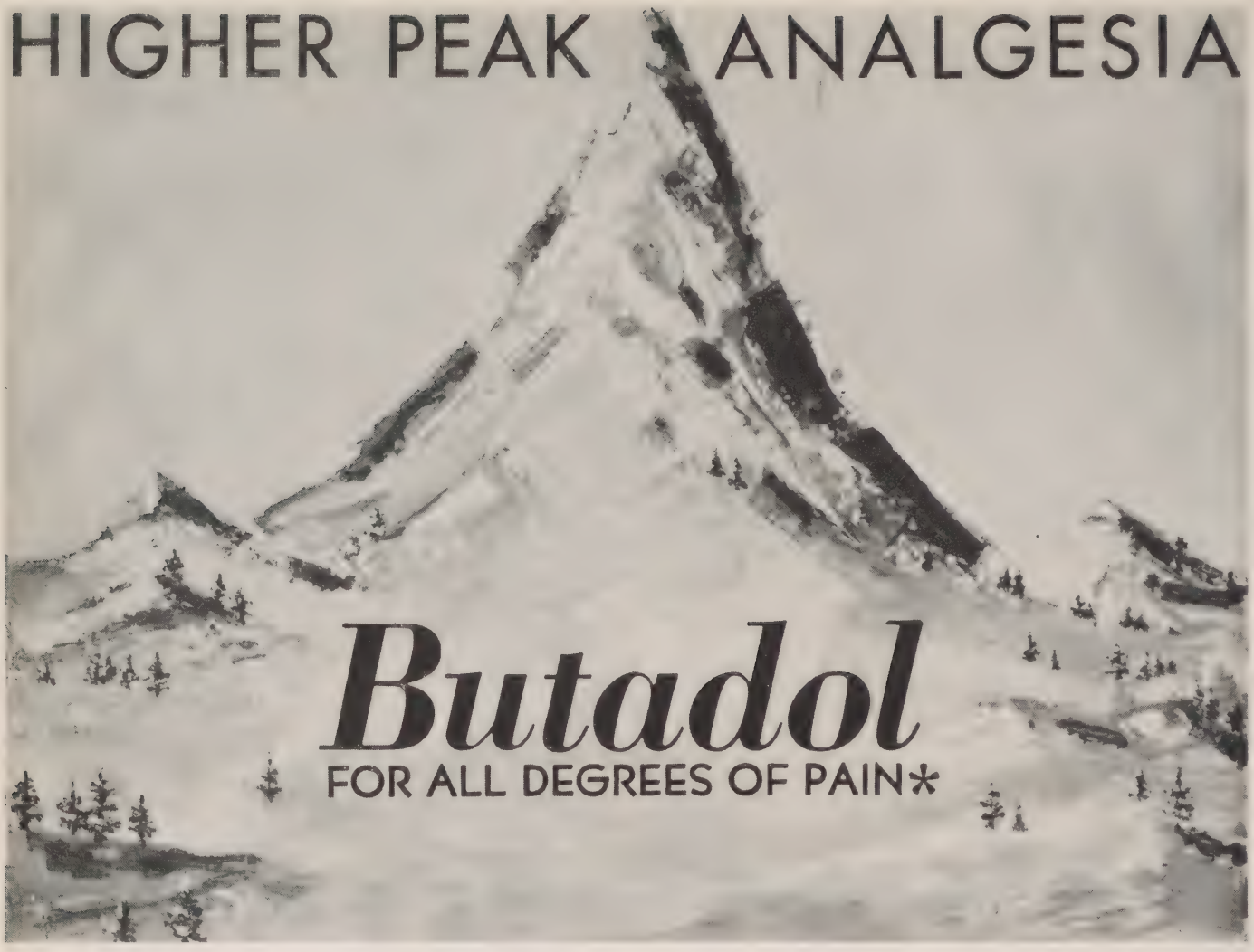
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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. 2. J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. 3. J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. 4. W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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Butadol and Butadol with Codeine may be habit forming.

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There are no known contraindications to Butadol when taken as directed. Excessive doses should be avoided due to barbiturate and atropine content. Infrequently, individuals sensitive to barbiturates may experience lassitude, headaches, nausea or emotional disturbance.

SIDE EFFECTS

Some patients may display allergylike skin reactions as the result of an acquired sensitivity to barbiturates.

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Butadol – Bottles of 100, 1000 and 5000 capsules.
Butadol with Codeine Phosphate (all 3 strengths) – Bottles of 100 and 500 capsules.

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Atropine Sulfate	.0012 mg.
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Hyoscyamine Sulfate	.024 mg.

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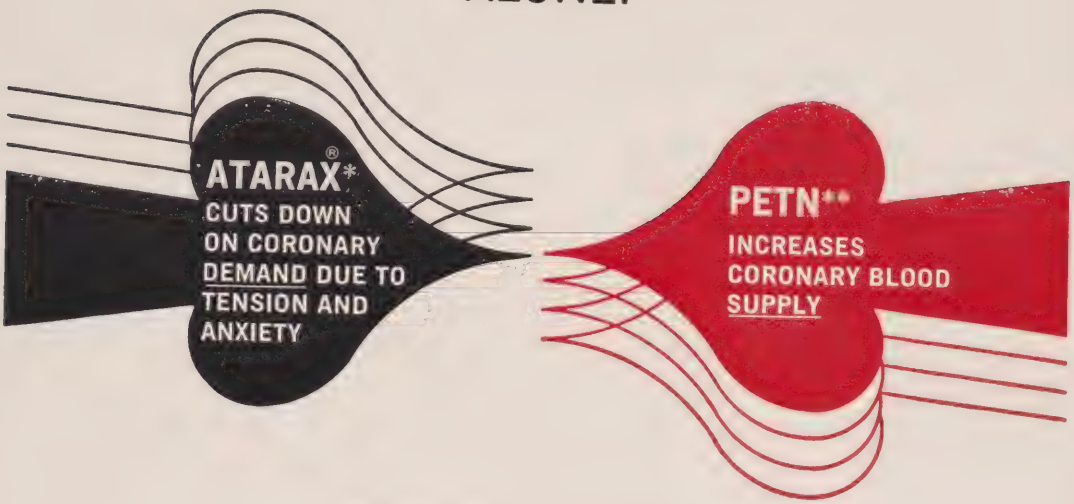
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1. Clark, T. E., and Jochem, G. G.: Angiology 11:361 (Aug.) 1960.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

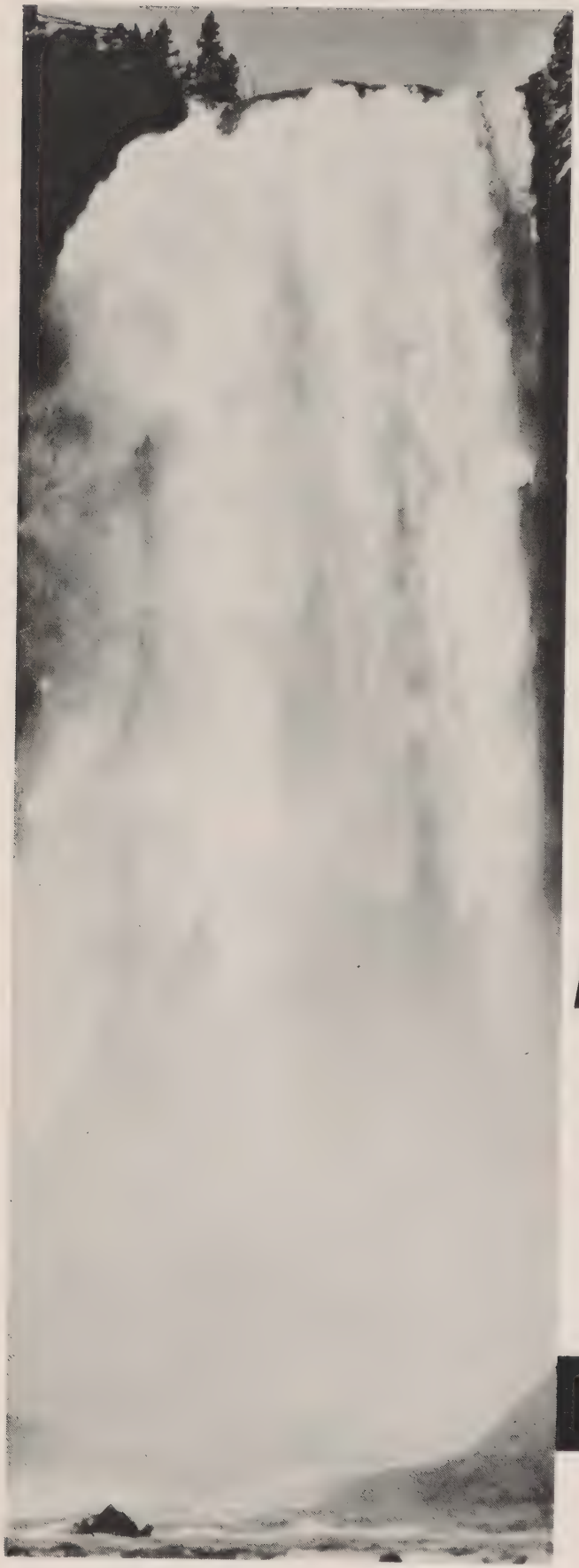
digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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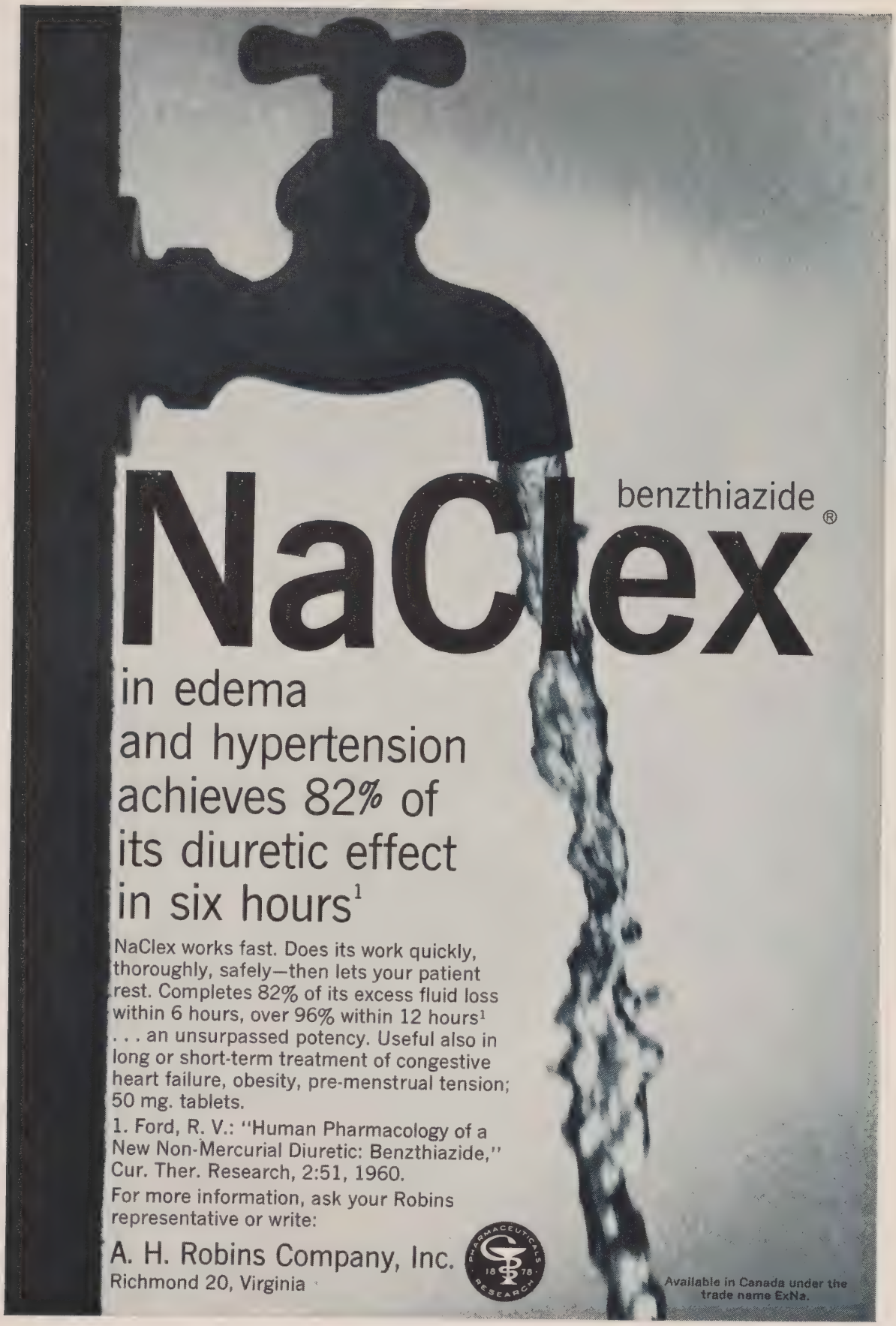
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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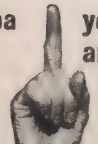


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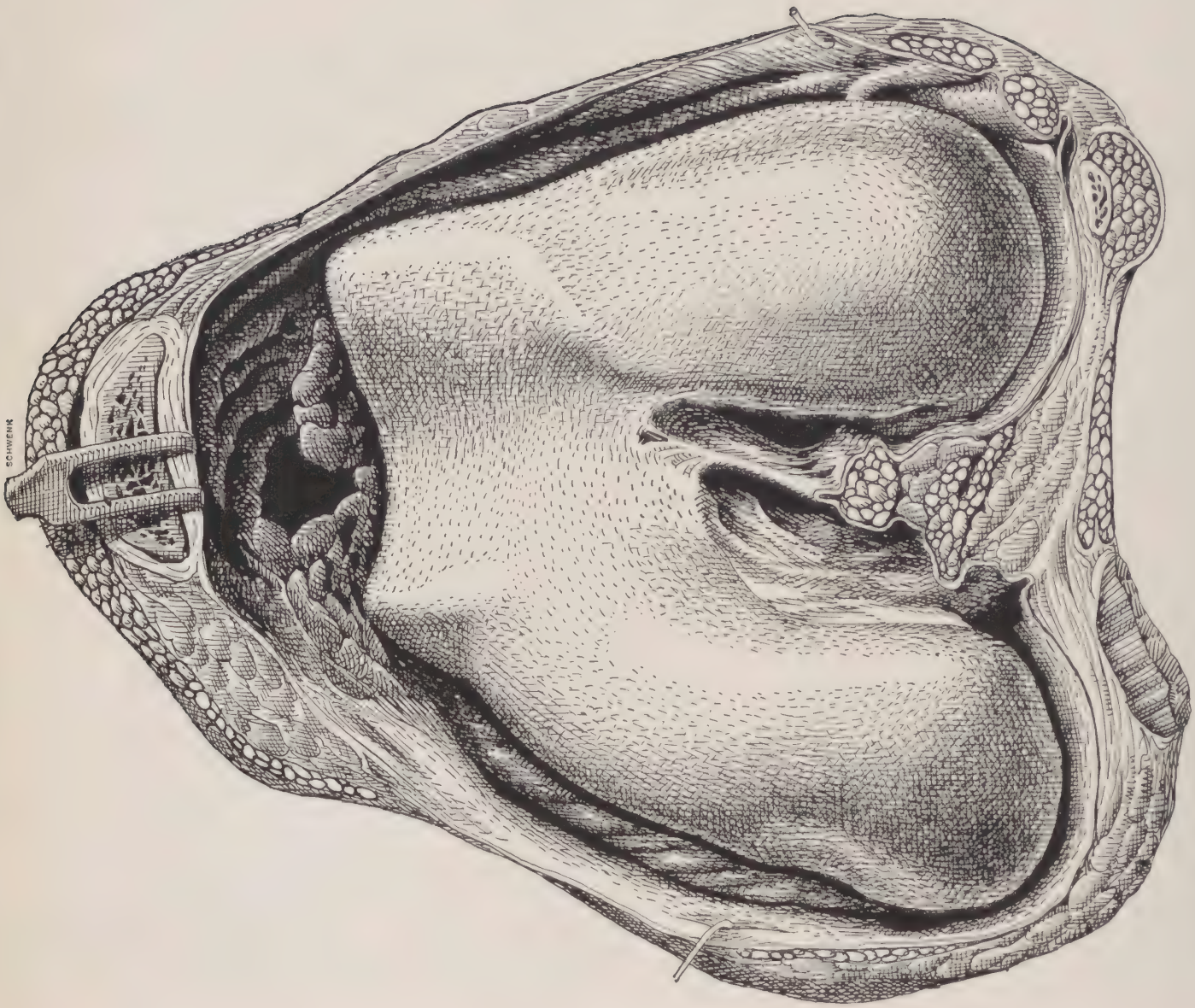
Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

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Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.
Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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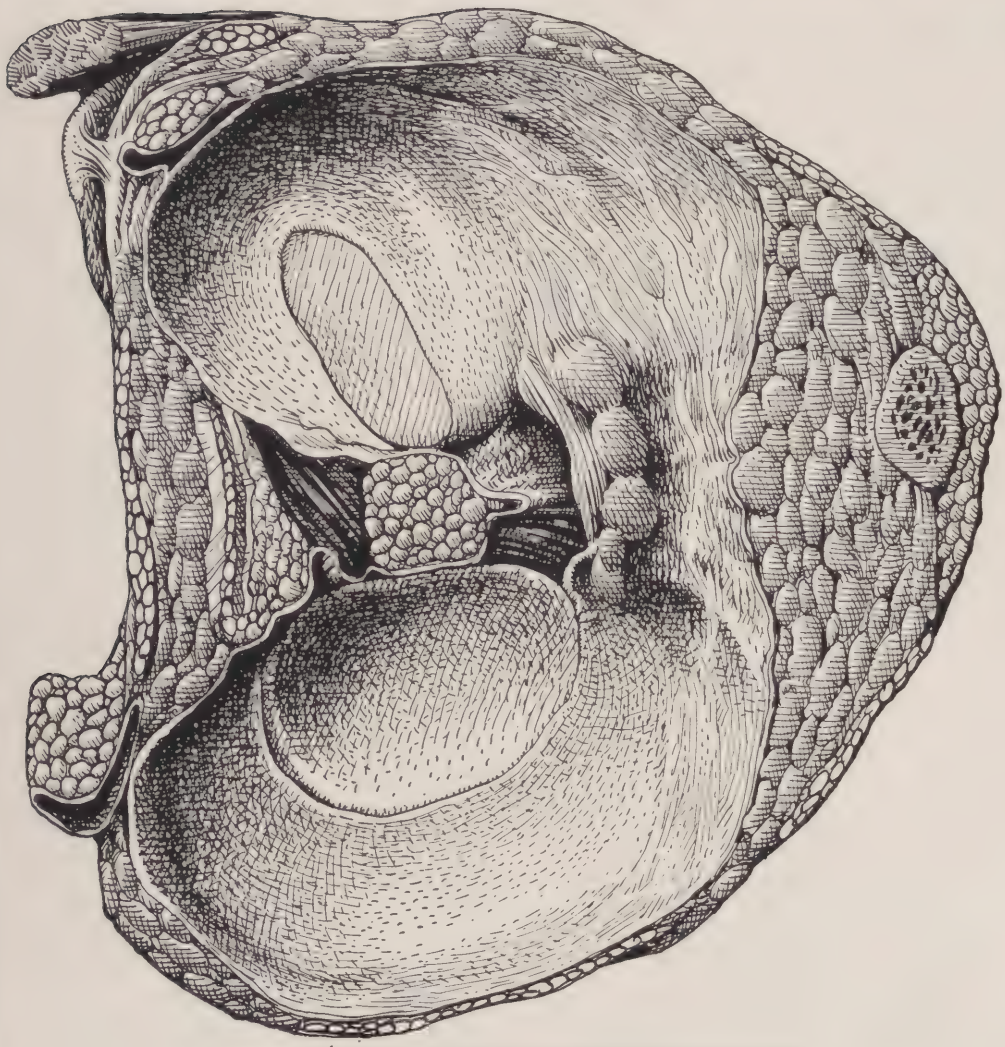
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The Thiazides

Situs Inversus

A Bedside Laboratory

Rupture of Ovarian Vessels

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Medical Television Program on Fractures - March 1

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VOLUME 58 FEBRUARY 1962 NUMBER 2

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CONTENTS

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ORIGINAL ARTICLES

An Evaluation of a Bedside Laboratory—*R. Randolph Bradham, M. D., Gilbert B. Bradham, M. D. and Richard H. Gadsden, Ph. D.* ---39

Diuretic and Hypotensive Mechanism of the Benzothiadiazines (Thiazides)—*Henry G. Howe, Jr., M. D.* ---43

Spontaneous Rupture of Ovarian Vessels in the Post-Partum Period—A Case Report—*William B. Helton, Jr., M. D.* ---50

MEDICAL COLLEGE CLINICS

Electrocardiogram of the Month—Situs Inversus with Dextrocardia—*Dale Groom, M. D.* ---52

EDITORIALS

Hospital Association Teeters ---54

Eating At Will ---54

Tuberculosis Resurrected ---55

Another for the Birds ---55

Caskets Forever ---55

FEATURES

President's Page ---53

Blue Cross . . . Blue Shield ---56

Civil Defense ---58

Public Relations ---59

News ---62

State Medical Journals as Advertising Media for Pharmaceutical Companies—Austin Smith, M. D. ---66

Deaths ---69

The Kefauver Bill ---70

What The Medical Profession Expects of Its Collection Representative—Henry C. Heins, Jr. ---71

A Letter From Dr. Marion Sims ---73

Book Reviews ---74

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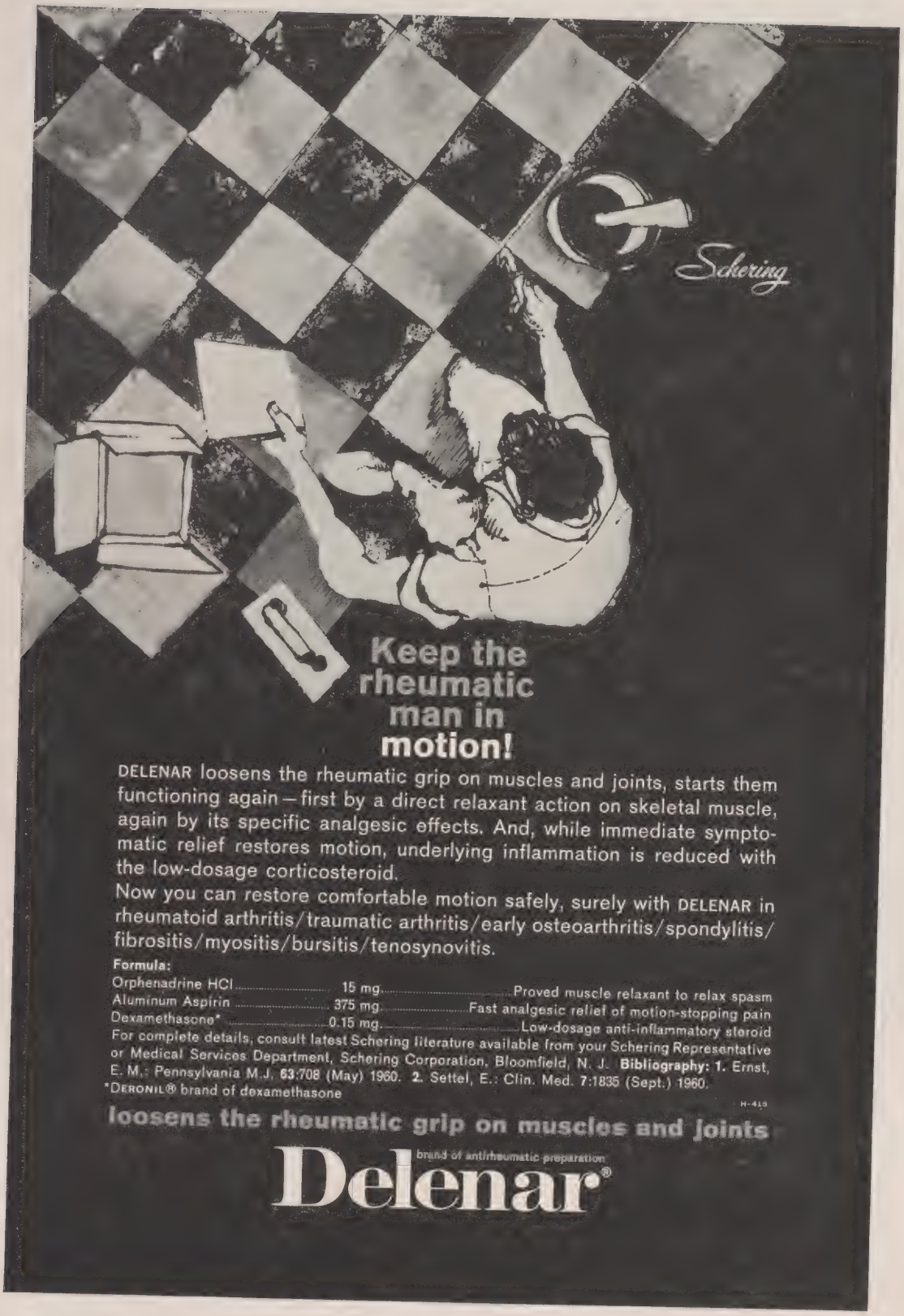
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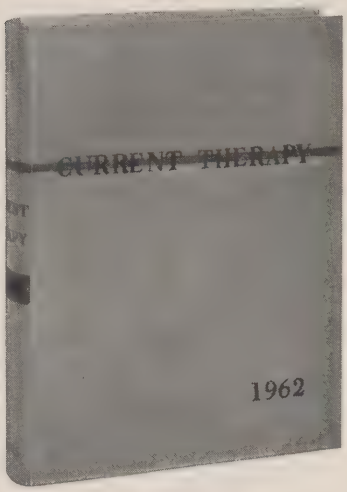
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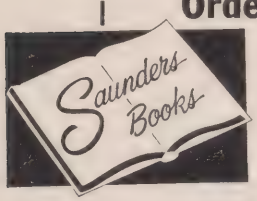
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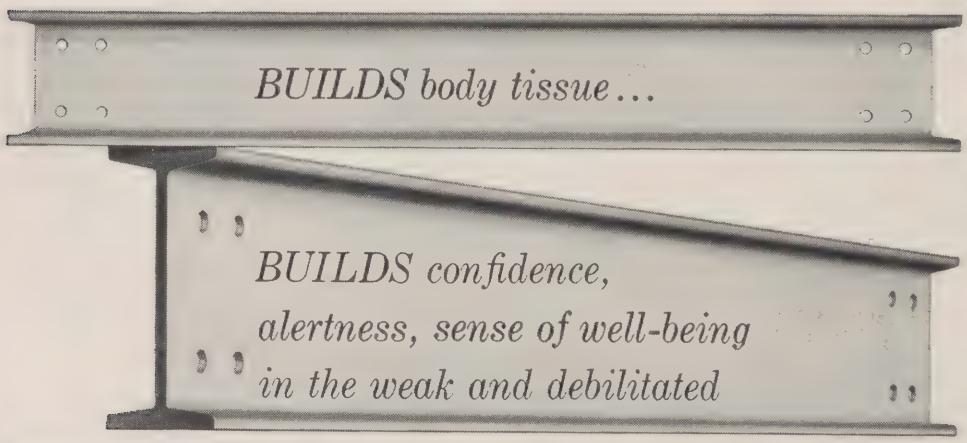
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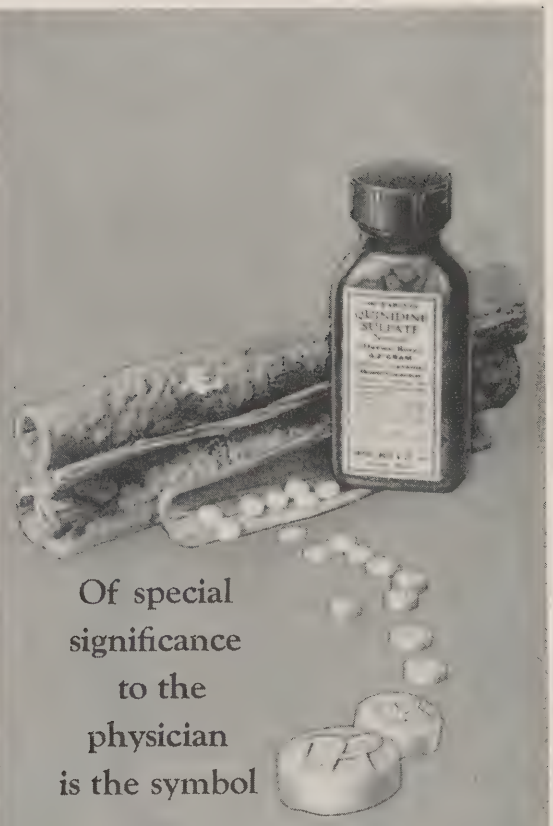
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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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The Journal
of the
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VOLUME 58 February, 1962 NUMBER 2

AN EVALUATION OF A BEDSIDE LABORATORY[1]

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Medical College of South Carolina, Charleston, S. C.

The development of a bedside laboratory that could be used for rapid, accurate, and economic determinations of serum electrolyte concentrations would be of great benefit to the clinician. Such a portable laboratory or kit could conceivably be used in smaller hospitals where there was not a clinical laboratory available. It could also be used to great advantage as a portable laboratory in hospitals caring for large numbers of critically ill patients. The resident on a busy surgical service could obtain electrolyte determinations quickly at the bedside of critically ill patients whose status was rapidly changing. The delay encountered in calling out a hospital technician at night would be obviated.

For such a bedside laboratory to be practical, the results of the determinations obtained must be accurate and the procedures simple enough to be carried out quickly by the technician or clinician after moderate practice. The kit must be compact and complete to allow transportation with facility.

Because of the numerous advantages of such a laboratory, one that is marketed was purchased and used on our surgical service. The bedside laboratory used in this study was based on the work of Scribner and associates.[1-5] One of us (G.B.B.), after moderate practice, used this laboratory to obtain bedside determinations of plasma concentrations of chloride, sodium (total base), and bicarbonate on ill patients.

Procedure

After satisfactory practice had been accomplished on standard solutions and plasma from patients, determinations were obtained on 24 patients and compared with those done on duplicate samples of blood, drawn at the same time, and analyzed in our biochemical laboratory. All bedside determinations were done by one of us (G.B.B.) so that errors in performance would be reduced to a minimum. In 16 patients, sodium (total base), chloride, and bicarbonate plasma concentrations were determined. In the other 8 patients either one or two different determinations were made. In

1. From the Departments of Surgery and Chemistry.
2. Associate Professor of Surgery.
3. Teaching Fellow in Surgery.
4. Assistant Professor of Chemistry.

This study was supported by a grant from the United Health and Medical Research Foundation of South Carolina, Inc.

all, there were 22 sodium (total base), 20 bicarbonate, and 20 chloride determinations. Instructions for each procedure were carefully followed.

Results

The results are categorized as to the determinations of each plasma concentration studied. All determinations done on one patient can be obtained by matching initials in Tables I, II, and III. The same initials appearing twice in one table indicates repeated determinations on the same patient.

Chloride: The results of the chloride determinations in 22 patients are given in Table I. In 10 of these patients the difference between the bedside determination and the amperometric titration determination was greater than 4 milliequivalents per liter. The differences ranged from +11.6 mEq./1 to −11.1 mEq./1.

Comment: Scribner[1] reported an accuracy of ± 1 per cent on duplicate determinations of plasma chloride. With one exception, his results on 20 consecutive samples of plasma agreed within a range of ±1.9% with results obtained by the silver nitrate method of Wilson and Ball. Results on urine specimens were equally accurate when the chloride concentration in the urine was greater than 50 mEq/1 but became less accurate when the concentration of chloride in the urine was less than 50 mEq/1.

Table I

PLASMA CHLORIDE

Comparison of values obtained by the Bedside method and the Amperometric titration method for plasma chloride. Results are expressed in milliequivalents per liter.

Patient	Bedside Method	Amperometric Titration Method	Difference
BK	97	92.4	+ 4.6
JS	102	98.6	+ 3.4
GS	85	84.5	+ 0.5
WO	102	105.3	− 3.3
LC	78	83	− 5.0
MB	103	91.3	+11.6
BR	103	96.1	+ 6.9
CS	96	101.9	− 5.9
DC	96	96.1	− 0.1
RL	105	102.3	+ 2.7
JW	91	85.4	+ 5.6
JW	92	90.1	+ 1.9
EW	97	91.9	+ 5.1
WK	85	96.1	−11.1
GG	107	102.8	+ 4.2
TF	107	102.8	+ 4.2
GT	105	102	+ 3.0
GG	110	109.6	+ 0.4
CC	103	102.2	+ 0.8
EW	102	100.7	+ 1.3
PR	100	98.2	+ 1.8
SD	97	96.1	+ 0.9

Sodium: It must be emphasized that by the method used in the bedside determination, total base was measured. Eleven milliequivalents per liter were subtracted from the total base to yield the value of the plasma sodium concentration. The results on 20 patients are given in Table II. In 12 of these patients the difference between the bedside determination and the determination by the Perkin-Elmer flame photometer was greater than 5 mEq/1. The difference ranged from +21.4 mEq/1 to —16.8 mEq/1.

Table II

PLASMA SODIUM

Comparison of values obtained by the Bedside Method and the Perkin-Elmer flame photometer method for plasma sodium. Results are expressed in milliequivalents per liter.

Patient	Bedside Method	Perkin-Elmer Flame Photometer Method	Difference
BK	134	132.1	+ 1.9
JS	139	151.3	−11.3
GS	130.5	134.2	− 3.7
WO	131	137.3	− 6.3
LC	123	126.9	− 3.9
LC	129	140.8	−11.8
WB	134	142.6	− 8.6
BR	136	133.9	+ 2.1
CS	159	139.2	+19.8
RL	136	139.2	− 3.2
JW	128.5	130.5	− 2.0
JW	119	128.6	− 9.6
EW	136	130.5	+ 5.5
GT	143	151.3	− 8.3
GG	140	142	− 2
CC	164	142.6	+21.4
EW	123	138.6	−15.6
RR	124	140.8	−16.8
SD	123	135.6	−12.6
WM	127	130.5	− 3.5

Comment: Scribner and Wiegert[5] reported results obtained on 26 patients with widely varying electrolyte and serum protein disturbances. The cation exchange resin column was used to determine total base. Total base values determined by this method were compared to the sum of the cations Na, K, Mg. and Ca which were individually determined. The standard deviation was 1.3 mEq/1. These authors cited that the greatest disadvantage to the bedside method was that most clinicians were used to thinking in terms of serum sodium. They indicated that this could usually be overcome by subtracting 11 mEq/1 from

the total base value to obtain the plasma sodium concentration. They warned that possible sources of error were (a) improper rinsing of the resin column, (b) severe jaundice or hemolysis, (c) carbonate contamination of NaOH, and (d) alterations in blood pH.

Bicarbonate: The results of bicarbonate determinations on 20 patients are given in Table III. In 14 of these patients, the differences between the bedside method and the Natelson Microgasometer method for determining plasma carbon dioxide was 3mEq/1 or greater. The differences ranged from +5.5 to −11 mEq/1.

Table III

PLASMA CARBON DIOXIDE

Comparison of values obtained by the Bedside method and the Natelson microgasometer method for plasma carbon dioxide. Results are expressed in milliequivalents per liter.

Patient	Bedside Method	Natelson Microgasometer Method	Difference
BK	23	19.3	+ 3.7
JS	30	41	−11
GS	41.5	36	+ 5.5
WO	26	23	+ 3
LC	30	30	0
LC	30	41	−11
BR	29	29	0
LS	30	34	− 4
RL	25	30	− 5
JW	21.5	33	− 8.5
JW	20	33	−13
WK	22	24	− 2
GG	19	17	+ 2
TF	19	19	0
GT	20	28	− 8
GG	15	12	− 3
CC	25	27	− 2
EW	10	20	−10
RR	25	29	− 4
SD	20	25	− 5

Comment: Scribner and Caillouette[3] reported on 31 consecutive samples of serum, the results being compared to those obtained by the volumetric method of Van Slyke. The standard deviation was 0.8 mEq/1. The mean value with the bedside method was 0.27 mEq/1 higher than the mean value with the Van Slyke method.

Discussion

The bedside laboratory evaluated in this study was compact and portable. All necessary reagents were arranged conveniently. To make a bedside determination, however, a portable centrifuge must be used for separation of plasma. If the specimen is not centrifuged at the bedside, it is necessary to add an anticogulant to prevent clotting.

Determination of the chloride ion concentration was found to be the most accurate of the methods available. It is a simple titration measurement with mercuric nitrate. With more than moderate practice, results should be relatively accurate. Results, however, would be influenced by alteration of the reagents used and inaccuracies in readings from the scale of small volume instruments.

The bicarbonate determination is dependent upon direct titration of base buffer capacity. The amount of bicarbonate ion present would be expected to change if a significant change in pCO_2 occurred between the time that the blood specimen was obtained and the time that the plasma was titrated. Negative pressure in the syringe created to withdraw the blood, exposure to atmospheric pressure during transportation, centrifugation and performance of the procedure, can all influence the carbon dioxide content and consequently the bicarbonate ion concentration present.

There appears to be reason for significant error in the determination of the sodium ion concentration. The total "available" base is measured by a cation exchange resin column. The bicarbonate ion value is then added to give total base concentration. An empirical value of 11 mEq/1, representing the sum of potassium, magnesium, and calcium ion concentrations, is subtracted to give the value of sodium ion concentration. Any error made in determination of bicarbonate ion concentration is transmitted to the determination of total base. If the sum of the non-sodium cations was greater or less than 11 mEq/1, another small error would be added. Another source of error is the exchange resin column where there might be an unequal exchange of cation.

Summary

A commercially available beside laboratory has been evaluated on the surgical wards of our hospital after moderate practice on standard solutions and plasma samples. This bedside laboratory is portable and conveniently

organized. A disadvantage is that it could not be used at the bedside unless a portable centrifuge was present. Plasma chloride, sodium, and bicarbonate ion determinations were obtained on a consecutive series of patients with varied fluid and electrolyte problems. Each ion concentration determination was evaluated separately. Determinations with the bedside laboratory were compared to the well established methods in the biochemical laboratory. The results with the bedside laboratory were not sufficiently dependable to warrant its use on our wards with changing house staff personnel. Sources of error for each determination were discussed. With intensive practice and use by one technician, this bedside laboratory might have practical value.

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Treatment of giardiasis with hydroxychloroquine—S. Kurban, J. Rosenbojm, and P. S. Rosenbojm. Rev. Hosp. Clin.—16:235 (May-June) 1961.

A study of the effectiveness of hydroxychloroquine in treating infections by *Giardia lamblia* was made in 5 stages, each stage involving 3 groups of 10 children. Group 1 was composed of children with giardiasis, being treated; Group 2 was composed of untreated children with giardiasis; and Group 3 was composed of healthy children. The division into stages aimed at (1) assessing results from the doses recommended in the literature, (2) standardizing the daily dose administered, (3) repeating the treatment, (4) standardizing the duration of therapy, and (5) standardizing the dosage per kilogram of body weight. Final results indicated that hydroxychloroquine is effective in treating giardiasis, having had a 70% rate of cure in the series studied. It is well tolerated, without any side-effects or alteration in skin color. The recommended dosage is 3 tablets of 300 mg. daily during 10 days, in contrast with the duration of 5 days recommended in the literature. No additional effect was obtained from a repeat treatment, nor from a dosage based on body weight. Although a higher percentage of clinical cure has been reported from use of quinacrine hydrochloride, hydroxychloroquine is considered preferable because of the absence of untoward reactions regardless of the patient's age.

Algae feeding in humans—R. C. Powell, E. M. Nevels, and M. E. McDowell. J. Nutr.—75:7 (Sept.) 1961.

The authors studied human feeding of algae in 5 healthy young male volunteers by adding algae as a supplement to the diet in amounts varying from 10 to 500 gm. per man per day. Although the bitter, strong, spinach-like flavor predominated in all foods supplemented with algae, the most acceptable preparations were cookies, chocolate cake, ginger-bread, and cold milk. Amounts up to 100 gm. per man daily were tolerated by all. When larger amounts were added, gastrointestinal symptoms were more prominent. These included nausea, vomiting, abdominal distention, flatulance, lower abdominal cramping pains, and bulky hard stools. No other evidence of toxicity was found and the gastrointestinal symptoms disappeared shortly after the feeding of algae was discontinued. It was concluded that heat treated, dried algae can be tolerated as a food supplement, but further processing will be necessary if algae are to be useful as a major food source. Methods to improve both acceptability and digestibility are needed.

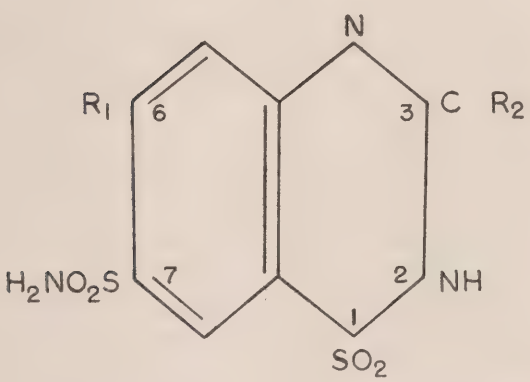
DIURETIC AND HYPOTENSIVE MECHANISM OF THE BENZOTHIADIAZINES (THIAZIDES)

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Medical College of S. C.
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A review of the recent literature leads to a discussion of the mechanism of the blockage of sodium and water by the proximal tubule of the kidney. This is followed by a discussion of how this action leads to an eventual reduction in mean arterial blood pressure. Several theories of mechanism are presented. In addition, the different appropriate drugs are listed with their structural changes and proper doses.

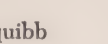
The history of the search for the benzothiadiazines (otherwise known as thiazide drugs) gives some insight into the mechanism of diuretic action that they exhibit. Sulfonamyl compounds, (the early example being sulfanilamide), were noted to have diuretic activity by having a specific action in blocking carbonic anhydrase. Blockage of this enzyme decreases availability of the hydrogen ion and hence decreases tubular absorption of sodium and bicarbonate. This results in increased excretion of sodium and bicarbonate and the urine pH increases. Potassium excretion is also enhanced. On a long term basis, therapy with carbonic anhydrase inhibitors results in potassium loss from the body and disturbances of acid base balance.

Basic Structure of Benzothiadiazine Diuretics



In the search for safer and more effective diuretics, investigators[3] developed a compound that combined a thiadiazine ring with a benzene ring which had a sulfamyl substitution at 7 and a chlorine substitution at 6. (Fig. 1.) Beyer[1] found that this compound, chlorothiazide introduced a new property, the ability to block sodium and chloride reabsorption by the renal tubule. The resultant diuretic effect is predominantly a natriuresis and chloruresis. These compounds act as though they were impairing the sodium pump in the proximal cells, thereby preventing the reabsorption of large quantities of sodium.[4] This action on the sodium pump is most selective in the more potent derivatives and very little carbonic anhydrase inhibitory activity remains. This action on sodium and chloride is referred to as a mercury-like action, and in dogs it is capable of inhibiting about 10% of the energy supply of the sodium pump. With one exception, changes in the chemical activity of the structure are made by substituting at the positions marked R-1 and R-2. Figure 2 presents the substituted groups at

BENZOTHIADIAZINE DIURETICS

GENERIC NAME	TRADE NAME	COMPANY	R_1	R_2	DAILY DOSE, MG.
Chlorothiazide	Diuril	Merck	Cl	H	500-1500
Flumethiazide	Ademol	Squibb	CF_3	H	500-1500
Hydrochlorothiazide	Hydrodiuril	Merck	Cl	H_2	50-150
	Esidrix	Ciba	Cl	H_2	
	Oretic	Abbott	Cl	H_2	
Hydroflumethiazide	Hydro Ademol	Squibb	CF_3	H_2	50-150
	Saluron	Bristol	CF_3	H_2	
Benzylthiomethyl-chlorothiazide	Naclex	Robins	Cl	CH_2-S-CH_2 	50-150
Trichloromethiazide	Naqua	Schering	Cl	H-$CHCl_2$	4-12
Benzylhydro-flumethiazide	Naturetin	Squibb	CF_3	H-CH_2 	5-15
Methylchlorothiazide	Enduron	Abbott	Cl	H-CH_2Cl	5-10
				*CH_3 at 2 position	

R-1 and R-2 of each of the benzothiadiazine compounds, their generic names, their trade names and their daily dosage in milligrams. The compounds are arranged roughly in the order of their natriuretic and chloruretic potency.

One outstanding feature seems to be the extreme change in activity with minor structural change involving R-1, R-2, or both. The initial effective benzothiadiazine was chlorothiazide. Simple addition of hydrogen at R-2 produces hydrochlorothiazide and the natriuretic potency increased about tenfold. The carbonic anhydrase inhibitory activity decreased about tenfold. The substitution of the trifluoromethyl (flumethiazide) group at the six position gave an equi-potent compound with less carbonic anhydrase inhibitory activity. Figure 3 shows the relative activities of these compounds in respect to natriuretic activity in rats and to carbonic anhydrase inhibition in vitro.[1] These values are approximate, but it is generally clear that there is a decreasing order of carbonic anhydrase inhibitory potency with increasing natriuretic potency. The chloruretic potency is in the same range as the natriuretic potency.

Excretion studies in dogs have revealed that carbonic anhydrase inhibition is nearly absent with effective diuretic doses of the more potent benzothiadiazines. These compounds are surprisingly non-toxic. In mice. rats, and dogs, several grams per kilogram given orally were without acute effect. Large doses administered daily for several months to dogs resulted in no evidences of toxicity. The oral effectiveness of all of these benzothiadiazines has been a

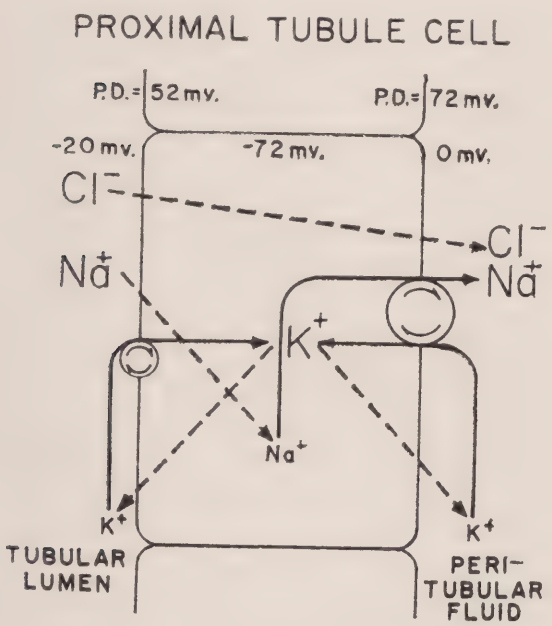
RELATIVE POTENCIES OF BENZOTHIADIAZINES AS CARBONIC ANHYDRASE INHIBITORS AND AS NATRIURETIC AGENTS

	Carbonic Anhydrase Inhibition	Natriuretic Activity
Sulfanilamide	1	--
Acetazolamide	200	--
Chlorothiazide	10	1
Hydrochlorothiazide	0.7	13
Flumethiazide	0.5	1
Hydroflumethiazide	0.1	13
Benzylhydro-flumethiazide	0.1	40
Trichloromethiazide	0.3	50
Benzylthiomethyl-chlorothiazide	--	13
Methylchlorothiazide	--	50

clinical advantage. Nearly complete and rapid absorption occurs from the alimentary canal. It must be remembered that although structural changes affect the natriuretic potency, these drugs have essentially the same natriuretic activity when used in the proper dosages as listed in Figure 2.

Whereas the mercurial diuretics lose their effectiveness in an alkaline urine and the carbonic anhydrase inhibitors lose their potency in a strongly acid urine, the benzothiadiazines retain their effectiveness in alkaline and acidic urine.

The concepts of the nature of the proximal tubular mechanisms which reabsorb sodium and chloride ions (Fig. 4) are admittedly in-



complete.[4] Proximal tubular cells, like most others, are polarized. The cell interior is about 70 millivolts negative to the surrounding peritubular fluid and about 50 millivolts negative to the tubular lumen. Because the cell surfaces which face lumen and peri-tubular fluid are polarized at different degrees, a potential difference (P.D.) exists across the tubular walls. The peri-tubular space is relatively positive to the lumen by some 20 millivolts. Negative chloride ions migrate along this electrical gradient from negative lumen to positive exterior. This transport is passive in sense that no energy is directly utilized in moving the chloride ions. However, energy is required to maintain the potential gradient along which the chloride ions migrate. and if that gradient is reduced, transport of chloride diminishes.

Most cells, including those making up the proximal tubules have a low sodium and a high potassium content; yet these cells are by no means impermeable to either ion. It follows that the sodium which diffuses into cells must be pumped out to keep the internal sodium concentration low; the potassium which diffuses out of cells must be pumped back in to keep the internal potassium concentration high. In muscle, nerve, red cells, etc., these ion pumps are coupled, that is, the exclusion of sodium and the accumulation of potassium are linked and occur symmetrically across all free cell surfaces. It is probable that the ion pumps of proximal tubular cells are also linked. However, these pumps differ in that they are located in the external surface of the cell, namely in that surface which faces the peri-tubular fluid. Hence, the sodium which diffuses into the cell from the lumen is extruded into the peri tubular fluid. The potassium which diffuses out of the cell into the peri-tubular fluid is pumped back in.

These ion pumps are responsible for the active reabsorption of sodium and require the continuous expenditure of energy. Since the cell surfaces facing both lumen and peritubular fluid are far more permeable to potassium than to sodium, the outward diffusion of potassium from high internal to low external concentration is a major determinant of cell polarization; negative inside, positive outside. However, the luminal surface of the cell is more permeable to sodium than the peritubular surface; hence, the free diffusion of sodium into the cell from the tubular lumen reduces the potential gradient across the luminal membrane and accounts for the transtubular potential of 20 millivolts.

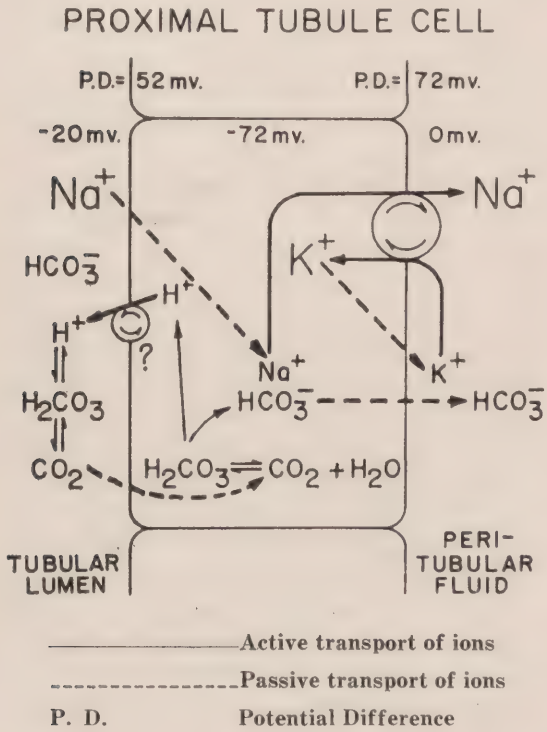
Little is known of the nature of these ion

pumps or of the metabolic processes which power them. Anoxia, cyanide, azide, etc., which interfere with the supply of oxidative energy to the pump, inhibit the reabsorption of sodium and chloride ions. Mercurial diuretics also inhibit the reabsorption of sodium and chloride ions, but whether by blocking the pumps directly, i.e. by preventing the attachment of sodium and potassium ions to the membrane carrier, or by reducing the supply of energy to the carrier is unknown.

Proximal tubular cells are freely permeable to water. The reabsorption of sodium chloride ions creates an osmotic force which causes the reabsorption of water.

Action of Carbonic Anhydrase Inhibitors

Carbonic anhydrase plays its role in providing within the cell a steady supply of carbonic acid from which hydrogen ions are dissociated. If carbonic anhydrase is inhibited, the concentration of hydrogen ions is reduced. Potassium ions, rather than hydrogen ions, are exchanged for sodium, and potassium excretion increases. Sodium excretion also increases as potassium substitutes for hydrogen incompletely in a ratio of about 3:2. Inhibition of carbonic anhydrase also reduces proximal tubular cells to form carbonic acid. (Fig. 5.) Ionization of this acid yields bicarbonate ions which diffuse along an electrical gradient into the peri-tubular fluid, and hydrogen ions which either diffuse or are pumped into the tubular urine. These hydrogen ions associate with bicarbonate ions in the tubular lumen and the carbonic acid formed slowly dehydrates to carbon dioxide and water. The carbon dioxide diffuses into the cells to enter the bicarbonate cycle. Inhibition of carbonic anhydrase reduces the availability of hydrogen ions within proximal cells and lessens their rate of transport into the tubular urine. Conversion of bicarbonate ions to carbon dioxide in the tubular urine is reduced and bicarbonate excretion increases. The characteristic features of the diuresis which results from inhibition of carbonic anhydrase include: increased sodium and bicarbonate excretion, reduced excretion of titratable acid, reduced excretion of ammonia, increased excretion of potassium, and little or no increase in the excretion of chloride.



Like the mercurial diuretics, the benzothiadiazines exert their natriuretic and chloruretic effects on the proximal tubules. There the similarity ends, for if one gives a large enough dose of a mercurial diuretic to produce maximal depression of sodium reabsorption, and then gives a large dose of chlorothiazide, the separte effects of the two drugs are additive. Accordingly, mercurial diuretics and the thiazides depress sodium and chloride reabsorption in the same segment of the proximal tubule in two different ways. Although explicable in other terms, the simplest view is that they reduce the energy available to the sodium transport mechanism by inhibiting two different metabolic pathways.

Use of the Thiazides

Chlorothiazide and its derivatives play an important and often primary part in the treatment of selected patients with hypertension. (Figure 6.) Given alone, these diuretics may not induce any striking reduction in blood pressure, but they greatly potentiate the action of other hypertensive drugs, the dosage of which can be reduced with a consequent lessening of unpleasant side effect. Further-

CHARACTERISTIC EFFECTS OF CHLOROTHIAZIDE

1. Prcduces a moderate reduction of basal blood pressure in hypertensive patients.
2. Enhances the anti-hypertensive effects of other agents, particularly the ganglion-blocking drugs.
3. In therapeutic dosages, it does not reduce basal blood pressure in normotensive subjects.

more, used in combination, chlorothiazide and other hypertensive agents achieve a smoother control of the blood pressure without sudden fluctuations. In some particularly severe refractory cases, satisfactory control may only be achieved by adding the more potent agents.

Experimental evidence[2] suggests that the fall in blood pressure produced by chlorothiazide is due to a reduction in the patient's plasma and extracellular fluid volumes. However, this probably does not account for the prolonged antihypertensive effect.

During the early phases of administration, the chlorothiazide group of drugs causes decreases in plasma and extracellular fluid volumes and total exchangeable sodium which are of the magnitude achieved with low sodium diets. However, as months pass, the deficits are repaired. For it has been shown that after six to twelve months of treatment, plasma and extracellular fluid volumes are no longer strikingly reduced, nor is this a reflection of resistance to the diuretics since discontinuance of the drug results in significant increases in these volumes.

The Mechanism of Hypotensive Action of the Thiazide Diuretics

In non-edematous hypertensive patients treated for periods of three to eight days with 500 mg. of chlorothiazide three times daily, there is a reduction of 1.5 to 3.5 liters of extracellular fluid volume as measured by the thiocyanate method.[2] At the same time there was a loss of 1 to 4 kg. of body weight. It will be noted that the estimated change of available fluid space was sufficient to account for the decrease in body weight. The data suggest, therefore, that the weight loss which follows the administration of chlorothiazide is derived from extracellular rather than the intracellular fluids. Parenteral mercurials also produce a decrease in the extracellular fluid space in non-edematous subjects.

In hypertensive patients who were treated for three to four days with chlorothiazide, and who were on a constant daily intake of salt, the accumulative negative balance of sodium measured 257 mEq.[2] In the same patients, the mean decrease in thiocyanate space was 2.8 liters, and weight loss averaged 3.0 kg. Thus, the total loss of sodium from body stores could easily be accounted for on the basis of an extracellular fluid loss alone.

The most likely interpretation of the action of chlorothiazide in non-edematous subjects is that its effects are no different qualitatively than in edematous patients. In each there is a mobilizable pool of extracellular fluid which can be skimmed off by saluretic agents or by severely limiting the dietary sodium intake. Once this labile pool has been eliminated, the saluretic agents are not able to deplete further the body's reserves of sodium and are effective only and to a progressively diminishing degree with the passage of time in maintaining the so-called dry weight of the treated subject.

Since the extracellular space and the plasma volume are in equilibrium across capillary walls, it is to be expected that a reduction in extracellular fluid volume will be accompanied by a fall in plasma volume. In hypertensive patients in whom simultaneous observations are made, the administration of chlorothiazide was followed by a reduction of 1 to 3 liters of available fluid and 150-550 ml. of plasma volume. A reduction in plasma volume has also been noted after mercurial diuretics in non-edematous subjects.

If the reduction in plasma volume plays a role in the antihypertensive mechanism of chlorothiazide, then re-expansion of plasma volume should reverse the antihypertensive effects of the drug. Partial to complete reversal of the antihypertensive action of chlorothiazide was observed when the patients were infused with 500 ml. of salt-containing or salt-free dextran.

If plasma volume change rather than cellular depletion of sodium is important in de-

termining the reduction of arterial pressure in hypertensive patients, then one would expect to find a reduction in right heart filling pressure and in cardiac output. (Figure 7.) Using

MECHANISM OF ACTION OF HYPOTENSIVE EFFECT OF THIAZIDE DERIVATIVES: SODIUM LOSS THEORY. (FREIS)

1. Non-edematous hypertensive patients. (After 3 days of chlorothiazide)
   - Diuresis of sodium and water
   - Reduction of plasma volume (15%)
   - Decreased right heart filling pressure
   - Decreased cardiac output (29%)
   - Decreased mean arterial pressure (15%)
   - Increased total peripheral resistance (33%)
   - 2-4 Kg weight loss
2. Non-edematous normotensive patients.
   - Decreased plasma volume
   - No reduction in mean arterial pressure
   - 1.5 - 2.5 Kg weight loss
3. Diminished responsiveness to norepinephrine and other pressor agents in both hypertensive and normotensive patients.
4. Infusion of salt-free dextran will restore the blood pressure to its former value in hypertensives.

right heart catheterization and the Fick principle in hypertensive patients, there was found an average reduction of 29% in cardiac output. Mean arterial blood pressure decreased by 15% and the total peripheral resistance increased 33%.

Normotensive subjects failed to show a decrease in basal arterial pressures following acute salt depletion. However, the plasma volume is reduced to the same extent as with hypertensive patients. The normotensive individual appears to have no difficulty in making the homeostatic adjustments so that his mean basal arterial pressure remains unchanged. The changes in filling pressure and cardiac output that occur in the normotensive subjects are not yet known, but from the slight fall in systolic and pulse pressure and the moderate increase in heart rate we may speculate that they are reduced and that compensation occurs through the baroreceptor reflexes which produce an increase in heart rate and total peripheral resistance.

Other Theories of Hypotensive Action

Other theories as to the mechanism of the hypotensive action of the saluretics include the proposal by Wilkins and Hollander[6] that these drugs may cause the neutralization or destruction of renin which is produced by the juxtaglomerular apparatus in the kidney and leads to the production of the powerful vasoconstrictor angiotensin. In addition, Tobian[5] has proposed that the hypotensive effect of these drugs is due to sodium depletion in vascular walls. His studies have shown that there is an increase in the salt and water content of arterial walls in human and experimental hypertension.

Complications

Complications of these drugs include: (1) Toxic reactions such as gastrointestinal upsets, diarrhea, weakness, hyperuricemia, and blood dyscrasias, especially thrombocytopenia. However, in the usual dosages given, these toxic reactions are no problem and are rarely seen. (2) Metabolic disturbances — mainly troubles in the electrolyte balance, i.e. hyponatremia, hypochloremia, alkalosis, and hypokalemia are considered a rather common effect of the prolonged administration of saluretic compounds. The most important of these is hypokalemia. Plasma potassium levels show a tendency towards a slight but continuous decrease in values below 3.0 mEq/1. This untoward effect, however, has satisfactorily been controlled by using a diet containing approximately 70 mEq. of potassium with addition of 10-20 mEq. of potassium tablets. (3) It has been found that the lowering of arterial pressure in hypertensive patients definitely decreases glomerular filtration rate and renal plasma flow and impairs water and electrolyte excretion to a considerable extent.

If kidney function is already reduced before treatment is started, further reduction may produce an augmentation of blood urea nitrogen far beyond normal levels. Hyperazotemia represents a more specific although by no means an absolute contraindication to saluretic treatment. Increase in blood urea nitrogen concentration can be induced by chlorothiazides or its derivatives, not only by an arterial hypotension such as to reduce renal function below critical levels, but also via a more direct reduction of glomerular filtration rate and possibly through an increase in urea reabsorption.

Arterial pressure has to be slightly and progressively decreased, an attentive eye being kept on the blood urea nitrogen and the hypotensive treatment being adapted to the BUN values, though there is no need to be excessively apprehensive about some slight transient increase in azotemia.

Summary

The pharmacology and theories as to the diuretic and hypotensive action of the benzothiadiazine or thiazide drugs are presented. It is thought that these drugs block the sodium pump in the proximal tubule thereby blocking reabsorption of sodium and water. This in turn leads to a reduction in plasma volume, which decreases the right heart filling pressure, and cardiac output which leads to a 15% reduction in mean arterial blood pressure. This seems to be the best of several theories for the hypotensive action of these drugs.

That another mechanism is operative in the long-term antihypertensive effects of these drugs is suggested by the findings that oligemia does not persist during months of chlorothiazide treatment when blood pressure reductions are still maintained.

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Adrenal tumor of the ovary with masculinization. A case report. Albert J. Baroody, M. D. (Florence). Am. J. Obstet. Gynec. 82:721 (Oct. 1961)

Twenty-four year old Negro female, nullipara. Irregular menstrual periods for 7 years. Amenorrhea varying from 2 months to 1 year. Facial and abdominal hair, enlarged clitoris, right ovary 6 to 7 cm. diameter. Uterus enlarged at times, but not pregnant. 17-ketosteroids elevated (94mg./24hr.) with decrease after cortisone suppression test.

Right ovary showed smooth grey capsule and dark brown (hemorrhagic) cut surface, with microscopic report of large, clear polyhedral cells of adrenal type. Pathologic diagnosis—adrenal tumor of ovary, apparently benign.

17-ketosteroids dropped to normal after surgery. Menses became normal. Pregnancy occurred 1½ years after surgery (aborted at 5 months) and again one year later, delivering at 8 months. Facial and pelvic hair returned to normal after one year. The clitoris became smaller but remained somewhat larger than normal.

Theories of origin and character of the tumor are discussed. Approximately 35 have been reported. An unusual feature of this case was the enlargement of the uterus, not noted in other reports.

Environmental antimicrobiosis with 2, 6-DIMOP penicillin in a nursery—J. M. Sutherland et al. Amer. J. Dis. Child.—102:793 (Dec.) 1961.

To test the results of Elek and Fleming (*Lancet* 2:568, 1960), 1.5 gm. of 2, 6-DIMOP penicillin (2, 6-dimethoxyphenyl penicillin monohydrate) were aerosolized into the air of a newborn nursery at 6-hourly intervals for 22 days. There was a decrease in the number of infants and adults from whom nasopharyngeal (NP) staphylococci could be isolated. In infants the decrease was noted, in NP cultures, first in coagulase+ and then in coagulase— staphylococci. Cord culture changes were later and less marked. Nasopharyngeal gram— organisms and streptococci decreased with the staphylococci. This was not noted in cord cultures, where gram— organisms and streptococci increased with the decrease in staphylococci. After the spray period, infants were colonized with organisms not encountered previously in the study. Before using 2, 6-DIMOP penicillin in environmental antimicrobiosis, possible dangerous colonization of susceptible populations, possible sensitization of infants or adults, and possible encouragement of 2, 6-DIMOP penicillin-resistant staphylococci must be weighed against the advantages to be gained.

SPONTANEOUS RUPTURE OF OVARIAN VESSELS IN THE POST-PARTUM PERIOD.

REPORT OF A CASE.

WILLIAM B. HELTON, JR., M. D.

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Rupture of the utero-ovarian vessels may occur at any time during a pregnancy or in the post-partum period. This may result in retroperitoneal bleeding, intraperitoneal bleeding or a combination of both. The patients usually present themselves with sudden severe pain in the lower abdomen and shock out of proportion to blood loss. The diagnosis must be kept in mind as the treatment must be rapidly instituted if the patient is to survive. The following case is typical, except that instead of rupture of utero-ovarian veins, which is usually the cause of bleeding, this is a case of spontaneous rupture of the ovarian artery and vein.

Case Report

This is the case of a 35 year old married white female Gravida five, Para four who had an uneventful prenatal course except for complaints of vague pain in the left lower quadrant of the abdomen. She was admitted on July 27, 1960 and had a spontaneous delivery of a normal female infant weighing 8 lbs. 11½ ounces after a two hour labor. She had a small second degree vaginal laceration which was repaired.

The patient was ambulatory and without complaint for the first 48 hours following delivery. At 5:00 a. m. on July 29, 1960, which was almost exactly 48 hours after delivery, the patient was awakened by the onset of a sudden vague pain in the left mid-abdomen. She felt the urge to defecate and got out of bed thinking this might relieve her pain. However, she fainted on the way to the toilet, hitting her head and left side. She regained consciousness and rang for the nurse who was unable to obtain a blood pressure reading and found the pulse to be weak and rapid. The patient was then examined by a house officer who noted difficulty in breathing, blood pressure of 40/0 mm. Hg, no peristalsis. The fundus was firm and well involuted, but there was a tender 6.0 cm. mass in the left mid-abdomen just lateral to the umbilicus. The patient was complaining of severe pain in her left mid-abdomen. Blood was drawn for typing and cross match and clot retraction which was normal. Injection of 1000 ml. 5% dextrose in water was started immediately.

Approximately one hour after her initial episode of pain she was examined by her private physician who could not feel a mass, noted slight distension of the abdomen and decreased peristalsis, no excessive external bleeding, no palpable pelvic mass on rectal examination. The fundus was firm and well involuted. The pulse was more steady at this time and the blood pressure was 70/40. No pulses were palpable in the lower extremities. The patient was more comfortable and complained only of hemorrhoidal pain.

Two hours after the onset of pain the blood pressure was 60/30, pulse 92, and the patient was no longer having pain. Nasal oxygen was started because of air hunger and 500 ml. of whole blood was started intravenously. General surgical consultation was obtained as the possibility of a sigmoid volvulus, ruptured viscus, or ruptured diverticulum as well as a retroperitoneal hematoma was considered.

The patient was taken to the operating room and an exploratory laparotomy was begun four hours after the initial onset of pain. When the abdomen was opened, a large retroperitoneal hematoma containing 700 to 800 ml. of blood was noted lateral to the sigmoid colon and having dissected under it. The peritoneum overlying the hematoma was opened and the hematoma evacuated. At this time bleeding started again and several large vessels were clamped and ligated. The largest was traced to its origin from the aorta and distally, and was found to be the ovarian artery severed approximately 6 inches from its origin. There was no evidence of arteriosclerosis present. The other vessels were thought to be ovarian veins. There was considerable distortion of the tissues by the hematoma, making positive anatomical identification of these vessels difficult. The patient's vital signs rapidly stabilized following the ligation of the vessels. The patient received a total of 1500 ml. whole blood.

She had a very comfortable post operative course; however, as she was febrile she was placed on chloramphenicol 250 mg. every six hours. She was discharged on the seventh post operative day.

Discussion

Hodgkinson and Christensen[1] in a review of 75 cases of ruptured utero-ovarian veins found that only 60% were related to labor or delivery. Williams[2] in 1904 emphasized the

unimportance of traumatic parturition as an etiological factor. In the cases reviewed the range was from 10 weeks gestation to 21 days post-partum.

In this review they felt that a sudden increase in venous pressure in connection with inherent vein wall weakness was the most important etiological factor predisposing to rupture. They explained this as being the cause for the 60% related to labor and delivery. In those cases not related to labor or delivery, they found that one half of the patients gave a history of some sort of straining or muscular activity that would increase the venous pressure such as defecation, coughing, lifting a small child, house cleaning, or coitus. Those remaining gave no history of anything that could possibly be expected to increase venous pressure.

The diagnosis is difficult but must be considered in any case with sudden onset of severe lower abdominal pain rapidly followed by shock out of proportion to the external blood loss. Labor and delivery frequently obscure the diagnosis. Samuel Norris[4] reported a case in which the accumulation of blood interfered with the contractile powers of the uterus and made control of the uterine hemorrhage impossible. He also pointed out that in this patient there was an intensive blue coloration of the vaginal mucosa, which may be helpful in diagnosis.

The overall mortality rate in Hodgkinson's and Christensen's review was 49.3%. The mortality rate for those in labor was 76.3% as compared to 30% for those occurring unrelated to labor. The case reported here was not related to labor and fortunately responded well to treatment.

The treatment is prompt surgery and may vary from evacuation of the hematoma and ligation of bleeding vessels, as in this case, to hysterectomy, which was necessary in the case reported by Norris. In those surviving surgery adequate antibiotic therapy should be instituted in order to prevent a fatal outcome due to subsequent infection in the hematoma site.

Summary

1. A case is reported of spontaneous rupture of the ovarian vessels 48 hours post-partum unrelated to trauma.
2. A review is given of the available previously reported cases with discussion of the possible etiology, prognosis, diagnosis, and treatment.

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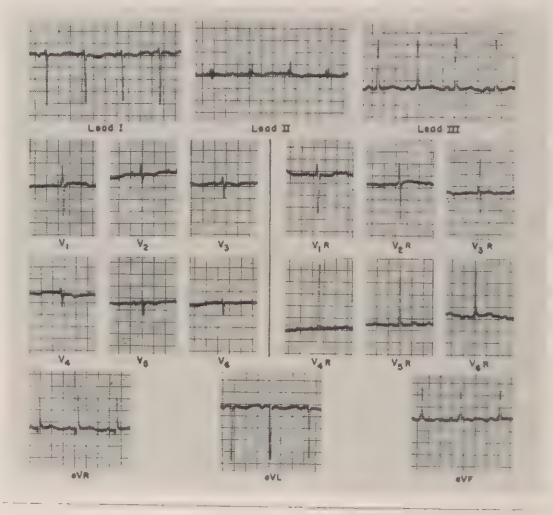
MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Situs Inversus with Dextrocardia

DALE GROOM, M. D.
Department of Medicine



Case Record—This composite electrocardiogram was made on a 16 year old colored patient during her last trimester of pregnancy. Interestingly, she had been examined several times without mention of a cardiac anomaly which was discovered on the ECG. Subsequent roentgenographic studies showed a complete situs inversus with the heart, stomach and spleen on the right side, the liver on the left. Beyond this and an elevation of blood pressure due to pre-eclampsia, there was no evidence of any cardiovascular or other abnormality.

Electrocardiogram—The top row of tracings comprises the three standard leads, the bottom row the unipolar limb leads, and in the center there are two sets of precordial leads: V_1 to V_6 in the conventional positions across the left chest on the left, and on the right the V leads taken in analogous positions over the right chest.

The notable features of this electrocardiogram are as follows:

1. The P waves and all major complexes in lead I are inverted.

2. The electrical axis is far to the right (aVR looks like a normal aVL, and vice versa).

3. The V leads illustrated on the left, taken in the conventional manner, do not show the normal increase in R waves and decrease in S waves with progression from the 1 to 6 positions but rather the reverse, whereas the V_1R to the V_6R leads look reasonably normal. Therefore the heart is on the right side of the chest and it is the heart, rather than the arm electrodes, which is reversed. And lead III is thus comparable to a normal lead II, and vice versa.

Additionally there are some minor T wave changes of a non-specific nature, not unusual in pregnancy.

Discussion—This is a case of true dextrocardia with complete lateral transposition of the heart chambers, great vessels and abdominal viscera. It is distinguished from *dextroposition* which is simply a shifting of the heart toward the right side of the chest as by pulmonary or other extracardiac disease, and *dextroversion* in which the apex may point toward the right but the left ventricle is still on the left and the right on the right side. In the latter situation, "isolated dextrocardia", septal defects and other serious congenital lesions arising from failure of the normal rotation of the septum in embryologic development are common. True dextrocardia, with inverted P waves in lead I and the right cardiac chambers on the left is almost always associated with complete transposition of the viscera, is frequently referred to as "mirror image dextrocardia" and is a developmental anomaly with, usually, no resultant abnormality. One should, however, establish that there actually is a complete situs inversus if only to know that the appendix and gall bladder are on the left side.

It should be pointed out that accidentally reversing the electrode leads to the two arms will produce the same pattern in the limb leads as seen here. And surely this must happen occasionally even in the best run laboratory. Conversely, the technician, seeing the complexes upside down in lead I may inadvertently mount that lead wrong side up (as did happen once in this case). The clue to such errors is of course in the precordial leads which confirm the right or left-sided position of the precordium.

Acknowledgement: My thanks to Dr. Cheves Smythe for submitting this electrocardiogram.



President's Page

Efforts within the state to organize a Speakers' Bureau for the purpose of letting the public know the medical profession's story about various matters have been highly successful. The members of the State Medical Association in twenty-two counties now have active bureaus, that are sending physicians to Civic clubs and other lay meetings, to let the public hear the medical profession's side of the story. This effort is being augmented by the Woman's Auxiliary, who are, through their membership in various women's clubs and organizations, aiding materially in creating a demand for these physician-speakers.

The State Association is following a plan very similar to that of the American Medical Association Bureau which is organized on the national basis. The AMA has emphasized its willingness to help the state and county societies at the local level, and has stressed the importance of the local physicians speaking in their own communities, because of their knowledge of the local people and problems, and because they have some idea of how these problems can be resolved. Further, the AMA offers a practical aid, in that it has a speaker's clinic that consists of an intensive one-day training program that can be arranged for those that are interested, in any state. This is set up to explain the basics of speech-making, and not necessarily to make polished orators.

The Speakers' Bureau is a powerful weapon against the enemies of organized medicine. Like all weapons, it needs a true and steady man to use it effectively. The speaker who is warm, sincere, and forthright, can work wonders for himself and for his profession. There is no necessity to be a silver tongued orator.

If your county society does not have a bureau, I would beg of the officers, to survey the membership, and see if you cannot organize and begin to let the people of your community hear medicine's side of the picture.

THE NEED IS URGENT.

Charles N. Wyatt, M. D.

Editorials

Hospital Association Teeters

First it was the nurses who came in opposition to the AMA in its stand for federal legislation to provide health care for the aged. Then it was the American Public Health Association, which came out in favor of Social Security financing for health care of the aged. Then it was other allied organizations, of somewhat less numerical importance, and now the American Hospital Association is wrestling with itself in order to determine whether or not the glitter of federal gold is going to sway its stand on the question of the care of the old people.

Although at its last annual meeting, the Hospital Association reaffirmed its opposition to the Bill, it hedged its decision by arranging for a special session to re-examine the organization's policy in advance of the new session of Congress. A special committee has been working on a report which has been given to the Association for consideration. Should the decision of the Association be adverse to its present policy, the thin red line of the AMA will be the only serious opposition to governmental and socialistic planning in this field.

Medical World News reports that some members of the Hospital Association, particularly in the south and southwest are opposing the suggestion of a change vigorously. All efforts are being made elsewhere to try to dissuade the powerful hospital group from taking a change in position.

There are many complexities in the consideration of a firm decision on this rather involved question. There is doubt expressed whether Blue Cross plans or the Kerr-Mills program can really meet the health demands of the majority of the aged. There is not much consideration of simpler measures which might avoid the complex administrative empires which must go along with governmental management. The AHA's Committee on policy will have a serious and hard question to answer. Significantly, there is no AMA representative on the Committee, a rather frank indication of a not-too-cordial attitude to the medical body.

Eating At Will

The whole structure of dietetic theory seems to be subject to a thorough shaking by certain observations at the National Heart Institute. It has long been customary for pediatricians particularly and dietetians and doctors in general to recommend that their patients stick to meal time eating, except for those who suffer with ulcers of the stomach and similar troubles. By this routine it was supposed that the digestive functions would work to a pleasant peak periodically and rest comfortably for hours between times.

Now whether the reader be chicken or not, he can draw his own conclusions from the results of experiments conducted on two groups of said birds. One batch was given free access to food for 24 hours every day. The other equal number of chickens were given food during two one-hour periods each day. The diet was identical and adequate. The dreary fact emerges that in these chickens at the end of five weeks the meal eaters had cholesterol levels twice as high and coronary atherosclerosis seven times as severe as did the nibblers, although the meal eaters actually had consumed about one-third less food. Again in another group in which atherosclerosis had been established by a special diet, it was found that those chickens who ate two meals exhibited a slower rate of fall of serum cholesterol levels to normal and a marked decrease in the rate of healing of the coronary lesions as compared to that in the nibblers.

If these experiments are fully confirmed, and if their conclusions can be transferred to humans, it looks like we must not only reform our diets but reverse our habits of eating and go back to the old primitive ways of eating at every opportunity. Perhaps the popularity of the numerous "breaks" in business establishments indicates an unconscious desire for the beneficial effects of frequent feedings, mixed

with a certain amount of innate laziness.

Beneficial as it may be to chickens, if carried to the human level, this chicken behavior might play havoc with many of our routine patterns of living.

Tuberculosis Resurrected

Have we been in too much of a hurry to assume that tuberculosis has been conquered, that we can close up our sanatoriums and expect the world to be free of this long dreaded plague? Certainly that was the sort of conclusion that has been reached by many optimists in very recent years.

Now the mass use of isoniazid to combat tuberculosis has been strongly condemned by able observers such as Dr. René J. DuBos, because of the fact that resistant strains are now appearing and the population is being subjected to a new type of organisms against which we have no satisfactory treatment. It is said that millions of people may now be harboring resistant strains which may be a serious threat to those in contact with these infected persons. Perhaps the closed sanatoriums will have to be dusted out and put back to use and efforts to find sources of infections will have to be redoubled along with the education of patients and their relatives.

Perhaps it was a coincidence, but in a conversation between two public health nurses from widely separated districts which was overheard a few days ago, unsolicited statements were made by both of them that they had noticed a very considerable increase in the number of their tuberculosis cases in recent months.

Another For The Birds

Histoplasmosis, a disease generally found in the Mississippi Valley area, appeared to be on the move with the help of our unwelcome starling population. An announcement comes from Washington that the fungus of the disease has been found in soil contaminated by starlings and taken from beneath sycamore trees in two of Washington's parks—and anyone who knows starlings knows that they can do a thorough job of contamination. Whether the starling is an actual carrier, or whether his fertilization of soil under his roosts makes proper grounds for the growth of fungus is not clarified in the report. Nevertheless he seems to be pretty well incriminated in the situation, and being already a pest now has to bear the burden of the accusation of promoting the spread of histoplasmosis from its usual rural and small town sites into a metropolitan area.

Caskets Forever

A completely new concept in caskets has been developed by Eternal Products of Long Beach, Calif. Called the "Epic" casket, it is made entirely of space age materials and is characterized by unique versatility. The new concept casket is light in weight, low in cost, convertible to twelve variations from hinge panel to couch or full panel, cremates with less residue than wood, and will not rot, rust, corrode or deteriorate. However, this information refers to the casket only.

Blue Shield Announces Plan For Medical Care of Aged

A nationwide Blue Shield program to provide surgical and medical care benefits for all persons over 65 at an estimated minimum cost of $3 a month a person was announced January 17 by the American Medical Association and Blue Shield officials.

The proposal came less than two weeks after the AHA and Blue Cross announced their private hospitalization plan for retired persons over 65.

The AMA said it is recommending that all state medical societies cooperate fully with their local Blue Shield affiliates to put the plan into operation as soon as possible.

The program completes organized medicine's battle lines to fight President Kennedy's plan to place health care of the aged under Social Security.

Both Blue Cross and Blue Shield plans involve the principle of ability to pay, with the needy receiving the most assistance.

John W. Castelluci, executive vice president of the National Association of Blue Shield Plans, said the proposed new program would provide for surgery whether performed in a hospital or a licensed nursing home.

BLUE CROSS . . . BLUE SHIELD

A New Dimension In Prolonged Illness Expense Coverage — Blue Cross - Blue Shield's Answer

National Health Care Costs

Examining national health care costs reveals the need for expansion of prepayment methods. Health need expenditures constitute four per cent of average individual earnings. This is proportionate with recent overall cost of living increases. The distribution of expenses comprising this four per cent, however, is inequitably distributed. A Health Information Foundation bulletin shows that catastrophic charges were incurred by 27% of prepaid families with half of these having charges in the $500-$750 range and one fifth having charges of over $1000.

Of the total health care bill of $19 billion, only 15% is covered by prepayment. This means that American families pay $15 to $16 billion out of pocket. This creates collection problems for the providers of care and disappointment for the partially prepaid public.

Even hospitals are only 50% covered and physician's services only 13% covered. The latter are covered somewhat higher in hospitalized cases. In these two areas, Blue Cross - Blue Shield does a much better job than other prepayment mechanisms. Blue Cross covers an average of 75-80% of hospital bills. Blue Shield, about two-thirds of in-hospital physician's services. Blue Cross - Blue Shield is able to do a better job because of its principle of paying for services actually required rather than limited dollar indemnities. Of course, higher price levels are needed to sustain this service benefit principle since it directly reflects the cost of services provided. In addition, rising costs of services require a proportionate increase in the price level of coverage.

Coverage for More Expensive Illnesses

Thus far, three approaches to problems of increasing costs, usage and competition have emerged. They are:

I. *An all-inclusive approach with presumed internal economic controls.*

The Commercial Major Medical expense policy is a typical example. This method says a family should pay initial deductibles of say, $50-$200 and 20 or 25 per cent thereafter. These Major Medical expense policies are used to either supplement basic coverage contracts or as a "comprehensive coverage," integrating basic and extended coverage.

There are disadvantages in this approach in that it does not always prevent economic hardship for a family. Large initial deductibles can be awkward to finance, not to mention the 20 per cent out-of-pocket expense which may be considerable if the total cost of the illness is truly "major." Another disadvantage is the high utilization resulting from a natural inclination to overuse a contract once the initial deductible is satisfied. As an example, if Joe Doakes' friend offers to pay 80% of the cost of a car, Joe's taste may improve somewhat. Similarly, there must be some controls in health care prepayment.

II. *The all-inclusive approach without control or limit.*

This approach says that all health care needs, regardless of place of occurrence or type of service, should be covered by prepayment dollars. This is the basic idea of socialized medicine, some unions, and the welfare groups.

The basic fact, here too, is that people in general cannot afford as much health care as they may think they desire. It also imposes an unnecessary burden on the providers of care. There must be some limitations if a program is to be helpful to the majority.

III. *Inclusive Services on a selective condition basis.*

This approach is essentially limited to Blue Cross - Blue Shield principles. That is, there should be adequate coverage when most needed, with built in controls against misuse of the program. A basic insurance principle is that the occurrence of the hazard insured should be beyond the control of the insured.

The Blue Plans recognize the need for expanding the *scope* of prepaid health care, especially for those services not rendered in hospitalized cases. This category accounts for 80% of the total public health bill. They also recognize the need for providing methods of prepayment which offer an extremely broad range of coverage for those persons who desire and are able to afford this type coverage.

The Best Method

Blue Cross - Blue Shield's new Prolonged Illness Contract now covers all illnesses and conditions. This contract has been expanded in order to answer the communities' needs for an even wider range of prepayment. This contract not only allows coverage of typically catastrophic illnesses, it also offers coverage for all other conditions which assume catastrophic proportions. Allowances have been increased overall for actual services performed, providing extensions of basic coverage. In addition, benefits are made available such as nursing care, home visits, and post-hospital care, which are not available under any of the basic contracts.

This new Prolonged Illness Contract now being offered was designed to best meet needs of a majority of subscribers and at the same time include those controls which are necessary. Article I of the contract best describes its scope and intent:

> "The benefits described in this certificate of contract are in addition to those provided in the basic SCHSP "(Blue Cross)" and SCMCP "(Blue Shield)" certificates of contract under which the subscriber and his dependents are enrolled. These benefits include additional days of care like those provided by the basic contracts as well as physicians' and related care for these additional days; for care provided in institutions other than general hospitals and on a non-hospitalized basis."

The new PIC covers two general categories of illnesses and conditions.

I. Those conditions of a typically catastrophic nature such as:
cancer
paralysis
progressive weakening of muscles
amputations
degenerative joint diseases
serious burns and fractures
tuberculosis
acute infarction of brain or myocardium
ulcerative colitis
enteritis
rheumatic fever
chorea
nephrosis or nephritis
psychosis

Benefits provided for category I are:

A. Physician's services
1. in hospital visits
2. home and office visits
3. consultations
4. diagnostic procedures
5. surgical services

B. Room and board
1. up to $12 per day in general or acute contagious disease hospital
2. $5 per day in nursing or convalescent homes

C. Ancillary services
1. full regular in-hospital charges excepting blood and plasma
2. full regular post-hospital charges for drugs, operating room, or out-patient department x-rays, lab exams, and physical therapy
3. $25 deductible per illness for drugs prescribed for out-hospital
4. $25 deductible on rental or purchase of appliances

D. Nurses services
1. eighty per cent of private duty nurses' charges up to 720 hours
2. charges of visiting nurse association

E. Benefits for tuberculosis
1. room and board up to 120th day of admission, including basic days up to amount provided in basic
2. ancillary services; regular hospital charges for drugs, medications, operating room, x-rays and x-ray therapy, lab exams, and physical therapy.

F. Benefits for mental conditions (acute psychotic)
1. In-hospital, 45 days per 12 month period
a. Physician's services and anesthesia for shock therapy
b. in-hospital visits
c. room and board, up to amount provided in basic
d. full hospital charges for x-rays, drugs, dressings, lab exams, and use of shock therapy equipment.
2. Post-hospital
a. physician's services for shock therapy and anesthesia
b. customary charges for x-rays, drugs, and lab exams

II. All conditions not listed in category I except maternity and related care and care of newborn.

Benefits provided for category II are:

A. In-hospital
1. physician's visits
2. room and board, up to basic amount
3. ancillary services (except blood and plasma) in member hospitals
4. eighty per cent of private duty-registered nurses charges up to $100

B. Post-hospital
1. physician's home visits
2. physician's services for diagnostic x-rays, lab exams, physical, x-ray, and radiation therapy
3. full regular hospital charges for diagnostic x-rays, lab exams, physical, x-ray, and radiation therapy
4. charges of visiting nurses' association

C. Not hospitalized
1. physician's home visits, subject to $25 deductible
2. physician's services for diagnostic x-rays, lab exams, physical therapy, subject to $25 deductible
3. fifty per cent of hospital's regular charges for diagnostic x-ray, lab exams, physical and radiation therapy, when rendered in out-patient department, subject to $25 deductible
4. charges of visiting nurses' association.

Benefit maximums for categories I and II are $10,000 or 24 consecutive months. The above conditions and allowances are only generally defined. Please refer to the PIC Contract for specific definitions.

It should be noted that this coverage has no overall deductible, monetary corridor between basic and

extended coverage, or co-insurance. The controls are obtained by specifically listing in the contract the general categories of illnesses and conditions that are covered and the degrees to which they are subject to benefits and controls.

Blue Cross - Blue Shield's reason for adding this all inclusive second category of conditions to those eligible for coverage is rather obvious. These diseases, while generally not posing a catastrophic problem, are nearly all capable of doing so, under unfavorable situations. When such an instance occurs, coverage is now available.

Conclusion

The new PIC is a sensible answer to the real needs of our communities' citizens. This program provides broad, easily obtainable benefits for all illnesses, once proven. There are two basic means of internal control used; one is the requirement that need is indicated, and another is that the recipient share, in part, the costs of services which might tend to be elective. More effective than any internal control, however, is the recognition by the providers of service, of the need for judicious usage of the benefits in the interest of a solvent community health program.

Robert E. Tomlin
Physician Relations Manager
S. C. Hospital Service Plan

Civil Defense



Outside the Mary Black Hospital in Spartanburg simulated casualties are unloaded from ambulances during the city's largest and most realistic disaster exercise held December 17. A cooperative effort by the Spartanburg Civil Defense Agency and the Medical Disaster Committee, the exercise gave medical personnel actual experience in handling mass casualties.

Despite intermittently heavy rain and chilling cold, Spartanburg conducted its largest and most realistic disaster demonstration on Sunday, December 17.

The test emergency, called "Exercise Hospitals," was designed to test the emergency operation plans of the Spartanburg Civil Defense units and the local medical facilities. The exercise also provided the hospitals, Spartanburg General and the Mary Black, practice in handling large numbers of casualties.

Touched off at 1 p. m. with a simulated boiler explosion at Spartanburg High School, the exercise developed with a fire started on the school grounds to add realism. As the alert was sounded, the Spartanburg Fire Department, Civil Defense rescue teams and Auxiliary Police sped to the scene. And, informed of the disaster, the two hospitals immediately put into operation plans developed under the direction of Dr. W. C. Herbert, Chief of Disaster Medical Care.

Within 15 minutes after the initial announcement of the disaster, the first of the 56 Boy Scout "casualties" began arriving at the hospitals. With the staffs mobilized for disaster operations, the simulated casualties were moved quickly through the triage (sorting) area where they were classified as to the degree of trauma, burns or a combination of both. Key Figures in this phase of the operations were Mr. Richard G. Roach, deputy to Dr. Herbert, and Dr. W. H. Hamilton, Chief of the Professional Branch.

By 3:15 the exercise was nearly completed and Spartanburg County Civil Defense Director Col. M. A. Fister closed operations at the high school. In all, some 300 persons took part in the disaster practice, including the National Guard, volunteer communications sections, the Salvation Army and the Red Cross.

Professional observers who evaluated the medical aspects of the exercise were Dr. R. K. Charles of Columbia and Dr. C. L. Guyton, Assistant State Health Officer. Prior to taking up positions at the Spartanburg General and the Mary Black, Dr. Charles and Dr. Guyton observed preparation for and initiation of the exercise at the high school.

Others who contributed their time and talent to the success of the exercise were: Dr. J. C. Hedden, Spartanburg County Health Officer; Dr. Leon Poole, Chief of the Emergency Hospital Division; Mr. Terry Brown, Chief, Supply and Transportation Branch; Mrs. Margaret Cudd, RN, Chief, Nurses Branch; and S. H. Ashcraft, Chief of the Pharmacist Branch.

Summarizing the exercise, S. C. Civil Defense Agency Director A. V. Thomas and his staff observers described it as "100 per cent successful."

Public Relations

ARE WE FIGHTING A BATTLE WE CAN WIN?

THE REV. ROBERT VARLEY, Th. D.,
Rector, Salisbury Parish
Salisbury, Maryland

It is a distinct privilege for me to stand before you and to share with you some observations of my own, on a matter of mutual concern. Nothing pleases a clergyman more than to have a captive audience. I must further admit that seeing a group this large does make me want to pass a collection plate. You see, we who deal in "eternity insurance" cannot gain our objectives by merely increasing taxes!

Also, I must note that your program committee must have had experience in dealing with speakers who are clergymen, for they not only assigned me my text, but they gave me a time limit, as well as wanting to read what I had to say ahead of time. Well, I like the text assigned, and I trust that I can stay within the allotted time!

Your program gives my text. A text is something a clergyman uses as a launching pad, promptly departs from, rarely, if ever, returns to, and has little or nothing to do with what he has to say. But I hope to prove this wrong. If we examine closely the topic at hand, this short phrase has within it all the words that are necessary to our concern.

"Are we fighting a battle we can win?"

All of us here are products of our age. Ours is an age with many faces. Ours is an age conceived in the dying decades of the industrial revolution; an age born in the tumultuous decades of scientific striving; and an age left to mature in the decades of a time whose character has not yet been determined. There is one thing we can say for certain about these decades—these have been and still are decades in which men have gone to battle and will still go to battle. And only as men of conviction fight can a victory be won. When men of conviction cease to fight, true freedom will perish from human society—perish a victim of the virus of apathy.

The battle grounds of our times have been as various as the men and women who waged the wars. The factory floors of England and America were, and still are, the battle grounds for the economic warfare wherein the contestants skirmish for men's minds. The one seeks to preserve human enterprise and individual ingenuity; the other seeks to submerge selfhood in the collective pot of conformity. The laboratories of science have ceased to be solely the battle ground where men fight human suffering and disease. They have, in our own time, become pawns of power for those who would submerge individual striving in the labyrinth of legislative control.

Perhaps the lines of battle are more closely drawn in the halls of education than anywhere else in our society. Our century has seen the educational processes of our land become the spawning ground for the fuzzy thinking of idealistic idiots who can find security only by submerging the ceaseless striving of individual intelligence in the swamp of socialistic scheming. All too often, socialistic planners wearing the honored habit of academic achievement hand down magnificent manifestoes for human living which are not only removed from reality, but are truly insensitive to the basic concept of life—a concept given by God in the very act of creation—the freedom to choose. To be free, a man must be free to choose! Man must live between the pull of heaven and the tug of hell. But he must be free to choose. Any system, any scheme, any plan which violates this dogma of dignity carries within it the seed of its own destruction.

It must not be overlooked that this battle is also being waged in the sanctuaries of faith also. Religion is life, and as such, organized religion reflects in its thinking today those who strive to preserve individual dignity and integrity—the pull of heaven; and those who seek safety in the cult of conformity—the tug of hell.

These battles are but symptoms of a cultural cancer creeping ceaselessly over all men who live lives in this age of tumult. Yes, we are engaged in a battle! Yes, we are fighting! Battles are always tragic, for they not only pit brother against brother, but even the victor suffers losses. The character of victory is found in the quantity of self-investment! The warfare of our times is total! To the victor goes the minds not only of those of us thus engaged, but also the minds and bodies of generations which have yet to see the dawn of day.

I believe that you here present must first realize that because you are on the battlefield does not mean that you started the war. The medical world has always been the prime target for pseudo-social planners, not because you are rich and powerful, as some would have the world believe, but rather because your training and professional insight represent the greatest threat to these idiot ideologists. Perhaps you do not

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realize it, but unless the medical world can be made the servant of socialism, the adversaries of individuality have lost the war before it really gets going.

Have you ever stopped to think what has made modern medicine in America great? The answer is your blessing and your curse. Modern medicine has molded the most fiercely independent profession in the world. Modern medicine rests upon the foundation of individual integrity, individual enterprise, individual initiative, and quite often independent action. The history of medical science is a list of individual biographies of heroes whose contributions to the well-being of man have freed us from the dread of disease.

Now is not the time for fierce independence. True maturity is found in a state of dependent-independence. The battle which rages around us is not the AMA's battle. It is our battle. It is not the physician fighting to maintain his independence. It isn't even the American physician fighting to preserve his patient's right to choose. The magnitude of the struggle is far more than this. Literally, we are engaged in a common battle against a common enemy. If we allow the world to view this as "the doctor's fight", then we will succumb to the oldest military strategy in the world—divide and conquer. We are in a fight, and we are in it together to win!

Can we win?? If victory is our goal, let history be our tutor! The pages of history are filled with the record of battles won and battles lost. In the lessons lie the answers we seek. Briefly, every man who has waged a war against an enemy—be that enemy a legion of men, a virus of destruction, or a philosophy of evil—has triumphed by wisely using four words—situation, problem, strategy, and tactic.

The present situation is well known; the cult of collectivism seeks through legislative action to socialize American medicine. The evils which Europe now seeks to shed are seeking new spawning grounds in America. This same situation finds expression in American industry and labor, in American education and professions, and yes, even in American religion and social life. The cult of conformity seeks to melt us down in the cauldron of collectivism.

To handle a single situation is not eradicating the underlying cause which gave birth to our present situation. A physician does not seek to relieve only a single symptom. He seeks to eradicate the causative agent. Then, and only then, can the patient be returned to full health. It is never enough to stop treatment with a diagnosis. Therapeutic agents must be prescribed. (If help is needed, I am certain that legislative committees will be all too willing to tell you not only the effects of therapeutic agents, but their side effects as well.)

The underlying problem can be briefly stated—pseudo-social planners in our day are attempting to erect a socialistic superstructure on a democratic base. To fully understand the depth and magnitude of this problem, you must leave the atmosphere of your profession, and through exposure to the voices of other disciplines and professions, see how widespread the problem is. I know how busy the American physician is. I know that he hardly has time to read the professional journals which are part of his tools. But I must say that only as we lift our eyes from the limited horizon of our own profession and view the problem in its complexity can we ever wage a full scale war against our common enemy. You are living in and dealing with "an age of anxiety", "a lonely crowd", the organization man", "the self in pilgrimage", and also "the cocktail hour". These are the voices of our time crying out to be heard by all men with a common concern.

To analyze the current situation and to diagnose the underlying problem leads inevitably to the third stage of battle—strategy. Once we leave our professional isolation, we become aware of allies in battle also. Professor William James once said "that those who are concerned with making the world better are the best start". A true strategist wants not only to know the strength of his enemy, he wants also to know the strength of his allies! From his allies he receives more than moral support. He receives man-power, supplies, aid and advice. Who in battle does not need allies? ? Who are your allies? ? We have heard from the adversaries. What have you heard from your allies? ?

One cannot hear from those one does not know! The American physician, and more particularly the American Medical Association, must reach out with as much vigor and determination for the help of its allies as it does to determine its detractors. The ancillary professions are filled with those not only willing but ready to join the fray but hesitate to do so until they are sought. They can be part of your "intelligence corps". They can provide depth to your reserves. Yes, they can even provide man-power in the day of battle.

Your strategy must include allied aid. Also your strategy must include means whereby the ranks of medicine itself can present a united front. All need not agree in philosophy. But all must agree in purpose. Currently, medicine is divided not only into specialties, but particularly in its approach. There are those in government medicine; those in academic medicine; those in research; those in hospitals, as well as those in "secular medicine". "A house divided cannot stand". Your strategy must include union within as well as without!

Adequate planning can come only in the light of all available resources!

Finally, the tactics of victory are found in an assault on reality! This is a real battle against real forces. We cannot afford to joust with the windmills of fantasy. A tactical invasion must be made upon the thinking of all our citizenry. The forces of folly have been doing this for decades. With platitude and promise, the minds of men have been swayed from the pathway of human enterprise. Ultimately as in the life of Jesus Christ Himself, you must first lead those whom you seek to serve. True leadership seeks to serve. The false leader feathers his nest with the dol-

lars he seeks to deny those who by the stint of hard work would earn in honesty.

Is it wrong, I ask you, through united effort, to recall the minds of the American public to their God-given obligation of working with their own hands? Is it wrong to seek to have every man put his hands on the plow of his own choosing, rather than to have his hand stretched out to receive the beneficent crumbs from a super-government—crumbs for which he has paid twofold through taxes hidden and undefined.

Is it wrong to expect the physician, the teacher, the clergyman to return to his role of guide and friend? When the mantle of leadership worn with dignity in generations past is allowed to fall from our shoulders, there are those forces all too willing to assume it and abuse it. Look at England today. Is there any virtue in being a physician in a state controlled medical system? The answer is written in the empty chairs in their medical schools. Yes, in a nation where only ten per cent of its population attend worship services—England—is there any virtue in being a clergyman? Where the mantle of guidance and friendship have been lost by neglect, the people follow other guides—blind guides who will fall into the ditch of their own digging.

The field of our battle is not in the labyrinth of legislature, not in halls of academic chambers, nor yet in committees of caucus. Our field of battle is in the homes where our people live, in the schools where they learn, in the offices and factories where they work, and in the churches where they pray. You cannot make a tactical assault on the forces against you unless you are in the field where these forces are at work! As the physician heals on the bed where the sick lie, let medicine lead in the streets where people live.

Are we fighting a battle we can win? ? Yes, we can win—win with men of good will.

Let full analysis of the current situation be your examination of symptoms. Let full understanding of the underlying problem be your diagnosis. Let adequate planning and forceful alliances be your prescription, and let a tactical assault on reality be your therapy of triumph!

With Goethe in "Faust", let us say:

"Yes, to this thought I hold with firm persistence
The last result of wisdom stamps it true
He only earns his freedom and existence
Who daily conquers them anew."

Reports by the American Medical Association and the Health, Education and Welfare Department showed that 38 states have taken advantage of the Kerr-Mills law providing medical care for the aged with a total expenditure of $121 million in the first 15 months of the program.

Citing the program's wide acceptance, Dr. Leonard W. Larson, president of the A. M. A., said that 27 states had enacted Kerr-Mills Medical Assistance to the Aged (MAA) programs and 11 other states had expanded Old Age Assistance (OAA) medical benefits under the new law.

In addition, he said, nine states already had OAA medical programs on the books and in most instances they are considered to be adequate to provide the necessary health care for those over 65.

Two of the three remaining states—Arizona, and Delaware—have excellent assistance programs at the local level which include medical care, Dr. Larson said.

"These figures certainly contradict statements by Kerr-Mills critics who say that the program can't and won't work," Dr. Larson said.

"In just 15 short months Kerr-Mills has been widely accepted across the land and with each passing day is proving that it can, and if given the fullest opportunity, will do the job.

"Kerr-Mills is being implemented by the states as fast, if not faster, than any previous federal-state matching program.

"Such rapid acceptance of this principle makes any compulsory health program through the social security mechanisms totally unnecessary."

A variety of new approaches to better care for the chronically ill and aged will be made possible through the Community Services and Facilities Act of 1961, HEW said. The Act authorizes grants to community agencies to develop new and improved home nursing, home care, and other out-of-hospital services. The Act also raises the ceiling for grants to the states for the construction of nursing homes from $10 million to $20 million annually.



Under the Hill-Burton program, 535 hospitals, nursing homes, rehabilitation centers, and other facilities were awarded $146,330,000 in Federal funds toward $468,661,000 of construction in 1961.

News

Aiken Group Elects Officers

The Aiken County Medical Society held its monthly meeting December 4 and elected officers for the ensuing year.

Those elected were Dr. S. G. Eaves, New Ellenton, president; Dr. T. W. Mappus, Langley, vice president; Dr. G. A. Poda, Aiken, secretary-treasurer; delegate to the S. C. Medical Convention, Dr. Poda, and alternates, Dr. W. Hamilton and Dr. J. Mathews.

Woman Doctor Opens Practice of Obstetrics

Dr. Christina Yates Parr has announced the opening of an obstetrics and gynecology practice at 1226 Pickens Street, Columbia.

Dr. Parr, born in Hwai Yuen, An., China, was graduated from Agnes Scott College with a B. A. degree. She was a member of Phi Beta Kappa and Chi Beta Phi.

She received her medical degree from Temple University Medical School. She was charter president of Alpha Omega Alpha, an honorary medical fraternity. She completed her internship at Michael Reese Hospital.

Dr. Parr received special training in obstetrics and gynecology at the Chicago Maternity Center and Chicago Wesley Memorial Hospital, a part of Northwestern University Medical School.

In 1958, she went as a medical missionary to Iran, stationed in Resht.

S. C. Hospital Gets Full-Time Psychiatrist

W. Strang S. Maclay, M. D., recently of Aberdeen, S. D., where he was assistant psychiatrist at the N. E. South Dakota Mental Health Center, has come to the South Carolina State Hospital as the first full time resident in psychiatry.

Dr. Maclay was born in Johannesburg, South Africa, and educated in England where he received a Master of Arts Degree, and the Degrees of Bachelor of Medicine and Surgery form Cambridge University, Cambridge, England.

Following graduation in 1955, a year was spent at St. Bartholemews Hospital, London, England, as house surgeon and intern. During 1956-1959 there was service as a captain in the Royal Army Medical Corps; with which service he is now on reserve status. After Army experience, Dr. Maclay was house physician at the North Middlesex Hospital, London, England; then general medical practitioner associated with Dr. M. G. Murray, Welwyn Garden City, Herts, England, prior to assuming his position at Aberdeen, South Dakota.

Dr. A. C. Smith Is County Doctor Of Year

Dr. A. C. Smith, Sr., a pioneer among area physicians, was honored December 9 as "Doctor of the Year" for 1961.

Spartanburg County Medical Society cited Dr. Smith at their annual dinner at the Country Club.

Dr. Smith, who will be 82 on Jan. 23, is still actively engaged in the practice of medicine. He has been for 56 years.

Columbia Medical Society Elects Seastrunk President

Dr. J. Gordon Seastrunk was named president-elect of the Columbia Medical Society at its annual election meeting December 12, at the Hotel Columbia.

Other officers elected were Dr. Hilla Sheriff, vice president; Dr. James Fort, secretary; Dr. J. W. Fouche, treasurer, and Dr. Buford S. Chappell, editor of *The Recorder,* the society's monthly publication.

Dr. James T. Green, named president-elect in 1960, will become the new president in January.

Outgoing officers are Dr. Weston C. Cook, president; Dr. Joe E. Freed, vice president; Dr. Charles R. Sloan, secretary; Dr. Waitus O. Tanner, treasurer, and Dr. P. F. LaBorde, editor of *The Recorder.*

Elected to three-year terms were Dr. John E. Holler, public relations committee; Dr. C. J. Lemmon, board of censors, and Dr. E. C. Kinder, executive committee.

The society re-elected Dr. Frank C. Owens, Dr. Waitus O. Tanner and Dr. C. J. Milling as delegates to the South Carolina Medical Association. Dr. C. Tucker Weston also was named a delegate.

Alternate delegates are Dr. R. G. Latimer, Dr. Frank Geiger, Dr. H. A. Skinner and Dr. Richard Wayburn.

Greenville Presidents Honored

Past presidents of the Greenville County Medical Society were paid special tribute at a meeting held Tuesday, December 5. Those attending were Drs. T. G. Goldsmith, Henry Ross, J. G. Murray, Joseph Crosland, A. Eugene Brown, William Edwards, L. H. McCalla, J. E. Lipscomb and M. Nachman. Also participating were Drs. J. W. McLean, Jack Parker, Will Fewell, Thomas Brockman, Asa Scarborough, Everette Poole, Joseph Converse, Keitt Smith, George Wilkerson, John Fewell and J. W. Jervey, Jr.

Dr. Durst Elected Again

Dr. George G. Durst of Sullivan's Island has now been elected president of Clemson College National Alumni Association for 1962.

New Film Available

"Life in Your Hands," a film produced by Smith Kline & French Laboratories in cooperation with The Johns Hopkins Medical Institutions, explains the use of the closed chest cardiac massage technique. This new teaching aid is now available free for use by physicians who conduct emergency resuscitation train-

ing programs for police, fire, industrial safety, professional lifeguard and other rescue groups with which they are affiliated.

Closed chest cardiac massage, also called external cardiac massage and manual heart compression, requires no special equipment and can be used anywhere. What is needed are the rescuer's knowledge of first-aid, his ability to apply direct breathing, and . . . two skilled hands.

Requests for prints and literature should be addressed to: Medical Film Center, Smith Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia 1, Pennsylvania.

Surgeon Opens Clemson Office

Dr. Edmund L. Rice has moved to Clemson and opened his office at 227 Pendleton Road.

His practice will be limited to surgery.

According to a statement issued by F. B. Adams, Jr., President of the Oconee County Medical Society, Dr. Rice has been accepted on the Courtesy staff for the practice of surgery at Oconee Memorial Hospital.

Dr. Rice returned this year from Lahors, West Pakistan where for eight years he served under the Methodist Board of Missions in the United Christian Hospital as medical director and chief surgeon.

A native Alabaman, Dr. Rice received his M. D. degree from Emory University in 1931. After three years of internship and residency training Dr. Rice went to China in 1934 to begin his medical missionary career. While in China he married Miss Mary D. Holler, a native South Carolinian. Dr. and Mrs. Rice served in mission hospitals in the Shanghai area until 1941 when they were forced to return to the States because of the political situation there.

During most of the years of World War II, Dr. Rice worked as surgeon in the Hugh Chatham Memorial Hospital, Elkin, N. C., a position he resigned to return to China at the close of the war. However due to the Communist encroachment, it was never considered safe for the family to follow, and after six months Dr. Rice returned to the States where he went into private practice of surgery in Gastonia, N. C. He gave up his practice to return to the mission field in 1953, this time to Pakistan.

In 1945 Dr. Rice became a fellow of the American College of Surgeons.

Health Center Planned For York County

York County is going to build a new $90,000 Health Department headquarters in York during 1962.

"We have already made preliminary application for $60,000 in federal Hill-Burton funds," said State Sen. Robert W. Hayes of Rock Hill.

He said the remaining $30,000 would come from the county sinking fund.

Greeleyville Gets Medical Building

A medical building will be erected on Main Street, Greeleyville.

The new structure will house a drug store, medical office, laboratory and emergency room.

U. S. Department of HEW

The Clinical Center of the National Institutes of Health has just published a new revision of "Current Clinical Studies and Patient Referral Procedures." The publication describes briefly the diagnostic requirements, purposes and methods of those studies expected to be most active during the current year.

Physicians desiring to receive a copy of the publication should write to Dr. Jack Masur, Director of the Clinical Center, NIH, Bethesda 14, Maryland.

Columbia Medical Society

The regular scientific meeting of the Columbia Medical Society will be held Monday, March 12, 1962, at 7:00 P. M. at the Hotel Columbia.

The guest speaker will be Dr. William H. Cassebaum, New York, N. Y., who will address members and guests of the Society on "Massive Gastric Hemorrhage, Problems, Diagnosis, and Treatment".

The local speaker will be Dr. Donald E. Saunders of Columbia.

Dr. James T. Green, President of the Columbia Medical Society, will preside at the meeting. Other new officers of the Society are: Dr. Hilla Sheriff, Vice-President; Dr. J. Gordon Seastrunk, President-Elect; Dr. James A. Fort, Secretary; Dr. James W. Fouche, Treasurer; and Dr. Buford S. Chappell, Editor of *The Recorder.*

Dr. Pulaski Opens Office

Dr. C. Pulaski of Hampton has opened an office for the general practice of medicine.

The 11th edition of *Diagnostic Standards and Classification of Tuberculosis,* with color illustrations and a number of revisions to bring it into conformity with present-day practice, has been published by the National Tuberculosis Association. This is the first edition since 1955.

AHA and Blue Cross Offer New Plan for Aged Care

A nationwide program of health care for the aged under private Blue Cross insurance with the federal government paying part of the bill was urged in early January by the American Hospital Association and the Blue Cross Association.

The proposal, in essence, provides free or very low cost care for the aged unable to finance it themselves, but retains the program under private control.

It would cover hospitalization, nursing home care, drugs, visiting nurses, rehabilitation or emergency services, with no restrictions because of present or past illnesses.

Persons would pay for this insurance in relation to the amount of their income and some would receive it free of charge.

The program would not, however, provide for doctor bills or surgery. Walter J. McNerney, president of Blue Cross who headed the task force that drafted the proposals, said a Blue Shield plan to provide the type

of medical care is in the rudimentary stage of discussion.

The health care proposal was explained to leaders of both associations and adopted by them in separate meetings January 4.

The American Medical Association, commenting on the hospital association position, said in a statement: "The American Medical Association is interested to learn that the House of Delegates of the American Hospital Association has gone on record that the best interest of the aged would not be served by the King-Anderson bill and that the House of Delegates opposes the use of the Social Security mechanism for the administration of any form of health care for the aged."

The King-Anderson bill would put medical and health care for the aged under the Social Security program.

Blue Cross officials estimated that minimum premiums for the health care insurance might run from 10 to $12 a month per person.

If 10 million persons, the number of aged not now considered able to pay hospital bills, were to receive such insurance free, the government bill would be about $1.5 billion a year.

However, the sliding scale proposed, Blue Cross officials said, would enable many of these persons to make some payment on the monthly premiums.

The new proposal is the result of a drive which developed within the American Hospital Association to break away from the AMA and take a separate stand on Federal legislation to provide health care for the aged.

According to a December 8 article in *Medical World News*, the drive to break with the AMA arose from a growing conviction among AHA leaders that time was running out for hospitals and that if they didn't come to terms with the public demand for Government-financed aged care, they would lose out altogether. Leaders and members alike felt that the Government might end up running the program as well as financing it and that Blue Cross would be virtually left out.

The AHA launched a review of the entire problem, including growing Blue Cross deficits and lagging implementation of the Kerr-Mills Bill. These activities culminated in the development of the new program.

MEDICAL TELEVISION

Thursday, March 1, 1962

(Second showing on March 2)

On Closed Circuit Educational Television Network throughout South Carolina

Title—"Pitfalls in the Treatment of Fractures"

Speakers—

Dr. John A. Siegling
Dr. Louie Jenkins
Dr. Frank Stelling
Moderator—Dr. Dale Groom

Annual Congresses

The Gill Memorial Eye, Ear and Throat Hospital announces its 35th Annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties April 2 through 6, 1962. For further information write: Superintendent, P. O. Box 1789, Roanoke, Va.

The American College of Allergists will hold its Graduate Instructional Course and 18th Annual Congress April 1-6, 1962, with headquarters at the Hotel Radisson, Minneapolis, Minn. For further information write: Dr. John D. Gillaspie, Treas., 2141 14th St., Boulder, Colorado.

Editorial Help

Dr. A. B. Nevling, recently retired as an active member of the staff of the Mayo Clinic and now an emeritus member, is engaged in private editorial work, revising and editing medical manuscripts. Dr. Nevling was an editor in the Section of Publications of the Mayo Clinic for 20 years and before that served as managing editor in the medical department of Thomas Nelson and Sons of New York. Anyone desiring his assistance may write him at 426 5th St., S. W., Rochester, Minn.

Dr. James C. Thrower Opens Office

James C. Thrower, M. D. has opened an office for the practice of medicine (practice limited to anesthesiology) at 1233 North Trinity Drive, Charleston, S. C.

Symposium on Thyroid Diseases

The New York State Society of Internal Medicine will sponsor a symposium on diseases of the thyroid gland March 3, 1962 at the Savoy Hilton Hotel in New York City. The list of speakers includes an impressive collection of physicians eminent in the field of thyroid disease.

A National Blood Serum Cholesterol Survey to be Conducted by the College of American Pathologists

The measurement of serum cholesterol as presently practiced is admittedly unsatisfactory because of wide variations in results. This variability is attributable to the use of diverse methods, and to the unavailability of an acceptable universal standard.

It is the purpose of the Standards Committee of the College of American Pathologists to characterize a best cholesterol standard for universal use, and to recommend an analytical procedure which may serve as a consistent point of reference.

This national preliminary survey of serum cholesterol estimations is being organized to disclose the present status of this chemical procedure. All laboratory directors and pathologists in the United States will be invited to participate.

Inquiries may be addressed to Cholesterol Survey, College of American Pathologists, Prudential Plaza, Chicago 1, Illinois.

Two Physicians Assume State Hospital Duties

Two additional physicians have assumed their positions on the staff of the South Carolina State Hospital.

Dr. Helen Hutchins Kuglar has been assigned to the Geriatric Service, Columbia Unit; and Dr. John C. Dunlap is on the Medical and Surgical Service, Columbia Unit.

Originally from Yadkinville, N. C., Dr. Kuglar received her medical degree from the University of North Carolina in 1957. After an internship in the University Hospital, Augusta, Ga., Dr. Kuglar was a resident physician in obstetrics and gynecology, at the Talmadge Hospital, Augusta, Ga.

A native of Rock Hill, Dr. Dunlap obtained his medical degree from the Medical College of South Carolina in 1960. Prior to reporting here, Dr. Dunlap served an internship at the Columbia Hospital, Columbia, S. C. He is a member of the U. S. Army Reserve Medical Corps.

Dr. Seymour Is Given New Post

Dr. W. Wesley Seymour has been named new assistant director of the Charleston County Health Department.

He fills a vacancy open since May when assistant director Dr. Malcolm U. Dantzler was named director. Dr. Dantzler succeeded Dr. Leon Banov, who now serves as consultant in preventative medicine.

A 1951 graduate of the Medical College of South Carolina, Dr. Seymour left the Veterans Administration Regional Office, out-patient Clinic, in Columbia, to take his new position.

Diet Notes

The American Diabetes Association, Inc., at 1 East 45th St. New York 17, New York, is an excellent source of good diabetic diets, especially suitable for private patients. These were prepared by committees from the American Diabetes Association, Inc. and the American Dietetic Association, in cooperation with Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare. There are nine "Meal Plans" of the following prescriptions with variable amounts of carbohydrate, fat, and protein.

For use with these diets is a booklet, entitled "Meal Planning with Exchange Lists", which offers many choices with which to vary the diet.

Sample copies of these diets and booklets may be obtained from me, on request.

The American Diabetes Association also publishes "A Cookbook for Diabetics" and a little magazine designed for the diabetic patient, entitled "Forecast".

I have simple, one-page diabetic diets, in mimeographed form of several prescriptions.

These may be obtained from me in moderate quantities, on request.

Margaret Freeman, Dietitian
Heart Disease Control Section
State Board of Health
Medical College Clinic
Medical College
Charleston, S. C.

The Watts Hospital Medical and Surgical Symposium

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STATE MEDICAL JOURNALS AS ADVERTISING MEDIA FOR PHARMACEUTICAL COMPANIES

AUSTIN SMITH, M. D.*

An advertiser may choose a journal because he believes the readership response of the journal will justify the advertising, because he believes in the objectives of the organization sponsoring the journal, or because he believes in the journal's editorial objectives. In general, state medical journals are among the periodicals which meet one or more of these criteria. And in my opinion they should be supported by companies who wish to influence physicians and who are anxious to preserve freedom of choice as a way of life.

Over the years I have had many opportunities to observe the standards by which various medical journals accept manuscripts and advertisements. The state medical journals have been among those seemingly anxious to raise these standards to the benefit of their readers. This was something I advocated while associated administratively with the American Medical Association and it is an objective which I still support. Your State Medical Journal Advertising Bureau has provided leadership for many years in this area and its work, and the efforts of its president, Alfred J. Jackson, should be a source of pride and satisfaction to all of you.

Of course leadership can be effective only if it is given support. And support can come from several directions but the most important for many medical journals are the readers and the advertisers. Advertising in a medical journal reflects faith in readership response and faith in the objectives of the journal or its sponsor. Pharmaceutical houses have increasingly supported the state medical journals although recently there has been a decrease in advertising volume as most of the members of this audience know. Frankly, I think this recession is temporary; the trend will return to a continuation upwards as soon as the uncertainty of the effect of a fallout from recent investigations of the drug industry is dispelled. In the meantime, faith on the part of the journal readers, their editorial leaders and their associated membership can help dispel this uncertainty.

On behalf of the pharmaceutical industry I would like to express appreciation for the interest shown in the recent hearings on drugs and on proposed legislation. The American Medical Association clearly saw the issues when its representatives testified. So in general did the state medical journals. Unfortunately, though, some people have failed to understand, or to report comprehensively the basic issues and the proffered testimony. They seemed to have lost the thoughts as they studied the words of those giving testimony. Furthermore, some have failed to wait until the story has been completely unfolded before they declared their views or urged action. For example, testimony has been offered on S. 1552 by members of the medical profession and some others but not yet by the Pharmaceutical Manufacturers Association. Nevertheless, even though the drug manufacturers have been giving careful thought to public welfare as it has been preparing its testimony and will reveal its positions on December 6, 7, and 8, some propounders of medical opinion have failed to wait for all the facts and already publicly have urged certain measures even though these subsequently may be shown not to be in the best interest of the medical welfare of this nation. Needless to say such actions have contributed to confusion for some and have been a source of glee for others.

Recently the PMA office studied the editorials and signed articles in medical journals on fourteen subjects ranging from drug brochures to drug research to S. 1552 to the investigation of the drug industry. This study embraced the period of July 1960 to September 1961. The sentiment was about four to one, according to these editorials and articles, in favor of the defense of certain long established principles. No one quarrels with the right to be critical of abuses. I have always been among those who believed—and still do—that abuses should be corrected and if criticism will effect such change, I always have—and will continue—raised my voice in protest. But at the same time I do believe fairness alone warrants seeking all of the facts, not just a few accusations.

Let me tell you the story of a wandering statistic to emphasize my point. It is not as important as currently proposed legislation but it reveals how confusion can be compounded.

This chronology traces a single statistic from its humble beginning to the pages of *Time* magazine. It shows how some of the most highly respected physicians and communicators of our nation can innocently nurse a statistic into a complete distortion of the truth. It points the moral that in criticising, including the pharmaceutical industry, physicians, scientists and writers should check their data with the same care as they would want accorded to life-saving treatment.

Each year, the "Drug Topics *Red Book*" publishes an exhaustive list of the products sold through wholesale and retail drug outlets. Several years ago at an annual meeting of the American Medical Association in San Francisco, a prominent Boston physician commented on figures from this publication as follows:

> "An advertisement for a recent edition of the "Red Book", which lists all of the 140,000

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* President, Pharmaceutical Manufacturers Association.

State Medical Journals Conference—October 31, 1961—Chicago.

> medicaments handled by pharmacists and available to physicians for patients, states that 14,000 new drugs were issued by drug manufacturers in 1953."

This and other statements in the address subsequently appeared as an article in a well-known national medical journal but unfortunately, in spite of his apparent care in describing the *Red Book* statistics, the author of the article used the word "medicaments" and failed to mention that these items include thousands of duplicate items, and range from prescription drugs to eyebrow pencil and perfume.

Three months after the article was published and at another annual meeting of the American Medical Association, a renowned physician, then professor of medicine at a New York medical school, delivered a lecture before one of the association's sections. This too, subsequently was published. Unfortunately the New York physician referred to the earlier article by the Boston physician and stated:

> ". . . Therapeutic preparations are confusingly numerous and varied. In the lists of 1953, more than 140,000 medicaments were available to practitioners, and 14,000 new preparations were added during the year."

Regrettably, he used the label "therapeutic preparations" and he too eliminated the necessary description of the *Red Book* figures.

When this latter article appeared in print an acknowledged marketing research authority of New York City, wrote to the author to check the source of his figures. The author responded by telephone and told the researcher that he had obtained the figures from the statistical department of his university. The researcher then consulted the statistical department and learned that its source was the same figures referred to misleadingly by the Boston physician.

Having studied the marketing figures of the industry for many years, the market researcher knew that the annual new products introductions totalled somewhere near 400, not 14,000, and he so informed the New York doctor and the statistical department of the university. And yet, five years later (1961) the editor of a medical journal published an editorial deploring the number of drugs now available and stated:

> "Five years ago, in an article (name of author) pointed out that to the already staggering total of about 140,000 medicaments in current use, of which an estimated 90% did not exist 25 years previously and 75% had been introduced within 10 years, some 14,000 new ones had been added during the current year . . ."

Thus, the distorted statistic returned to active service after a five-year furlough.

The market researcher who recognized the errors five years ago wrote to the editor of the editorial to give him accurate figures. Meanwhile the news bureau of this editor's university put out a news release based on the medical journal editorial, as the editor was a member of the university staff. This release was picked up by the Associated Press, by the *Newark Evening News*, and by *Time* magazine, among others. Here is how *Time* magazine in part used the statistic:

> "No fewer than 150,000 preparations are now in use, of which 90% did not exist 25 years ago, and 75% did not exist ten years ago. About 15,000 new mixtures and dosages hit the market each year, while about 12,000 die off."

Comparing *Time's* version with the previous ones, it is evident that a new element of distortion was added. For the first time the figures are boosted to 150,000 preparations total and 15,000 added per year. *Time's* use of the words "new mixtures and dosages" may look like a step toward accuracy but to me they merely confirm ignorance of the actual nature of the *Red Book* listings. No indication is given of the source of the information that "12,000 die off" each year.

As an isolated problem the above case is scarcely cause for panic. However, it is disturbing as one more episode in a long history of factual distortions about one part of this country's health picture, the prescription drug industry. And I mention it to the members of this audience because of the nature of the work and because there is need for all of us to be properly informed about the elements of medical care and their costs.

A classic case of distorted statistics began on December 7, 1959, when the chairman of the Senate Subcommittee on Antitrust and Monopoly, discussing costs of prednisone during the recent drug price hearings turned to an associate in the Senate hearing room and asked, "What is the percentage of the markup from $1.57 to $17.90?" In reply Dr. John Blair said:

> "Mr. Chairman, it is 1,118 per cent markup, roughly 11 times . . . ." Mr. (Francis) Brown: the president of Schering Corporation, who was in the witness chair retorted: "If I may be permitted to do so, I would like to say I consider this not to be the proper relationship, because this does not include the expenses of doing business which I have outlined. This only includes the bare factory production costs . . . ."

In spite of Mr. Brown's explanation the result of the question and reply was immediate, predictable, and irreversible. The nation's press promptly headlined the raw percentages, and converted markup into profit. "PROFITEERING CHARGED TO DRUG FIRM", shouted the *Philadelphia Inquirer* (December 8, 1959). "DRUG FIRM TOOK MARKUP OF 1,118 P. C., PROBERS SAY" proclaimed the *Baltimore Sun* (December 7, 1959). In the stories, but lost under the weight of the headlines, was the qualification that reference to this markup did not include most of the cost of business. Lost was Schering President Brown's statement to the press that his over-all profit was 16%, and that his prednisone profit is probably around 12%.

The *Baltimore Sun* commented on this and other arithmetic as follows:

> "The subcommittee contended that research costs for Schering were about 8½ per cent of its sales last year while the industry's distribution costs averaged 23½ per cent.
> "Add 8½ per cent and 23½ per cent," the Tennesseean commented, "and it's a long way from 1,118 per cent."

The serious subject of fatalities during clinical investigation of drugs was also put through the wringer of statistical distortion during the drug hearings. A highly publicized hearing-room debate took place during discussions on the oral anti-diabetic Diabinese. An eminent physician included in his prepared statement for the hearings the following sentence:

> "At the time of application to the FDA some 2,000 case reports were submitted and despite the inclusion of 43 deaths and a number of instances of jaundice the drug was passed for public sale in 1958."

Fortunately, some of the press reports include the strong denial of this figure by other medical witnesses. The *Washington Post* (April 28, 1960), for instance goes on to say:

> "Later, he (the accusing physician) told a reporter that only eight deaths could be traced to the drug."

But a serious loss of public confidence both in the drug and in the judgment of their physicians resulted according to other testimony presented on subsequent days. The drug industry has frequently been the butt of criticism about "misleading" promotion. But the companies would have to go far to outdo the misrepresentations put forth by some of their critics. A prime example occurred during the drug hearings when a testifying physician stated:

> "An example of a big promotional idea was that of Smith Kline & French who in October 1957 sent this assorted sample package of drugs to my office, and it is assumed to all 150,000 doctors' offices throughout the country, and as shown here in the statement, the wholesale cost of these drugs amounts to $18.99. The postage alone — 4 pounds — amounted to $1.05. When estimated for all 150,000 doctors, it comes to the wholesale cost of the drug, $2,248,500 and the postage at $157,000 making a total for that one promotional campaign of slightly over $3 million."

The critic's assumption was of course completely erroneous. The distribution of the packet was limited to some 6,000 physicians, mostly new doctors being introduced to SK&F products, and cost not three million dollars but around $100,000.

A much more serious case of statistical inaccuracy occurred more recently. A former participant in the drug hearings was being questioned by a Senate committee. He commented on drugs among other things. In preparing a story about this hearing, United Press International stated on May 31:

> "About 24 cents of every dollar that the American consumer spends on prescription medicine is used by the drug makers to advertise and promote their products. Paul Rand Dixon, Chairman of the Federal Trade Commission, gave this statistic to UPI following recent testimony before a House committee . . ."

Several errors were built into that figure. The reported figure covers everything from advertising to warehouses to returned goods. The importance of this distinction can be seen in the figures published in the June 13, 1960 issue of *Chemical & Engineering News*:

> "The bill for promotion and advertising? Not out of line, according to company figures. Parke, Davis spent less than 3% of sales in 1959 for promotion and advertising. At Abbott, the bill for advertising in 1959 ran about 6% of sales. Upjohn says its outlays for such activities in 1959 ran about 6.6% of sales, down from 7.6% in 1958 . . . ."

The United States is today embroiled in fundamental conflict over the methods of providing health care. Our individual and national health hang in the balance. Under attack is the free practice of medicine and the competitive enterprise system of supplying health services. Only through full knowledge of the most accurate information obtainable will the American public be able to make the wisest decisions. The debate cannot help being emotional, but there is absolutely no room for dubious statistics.

We in the medical profession and the pharmaceutical industry have been accused too often of being ultra-conservative. I do not think we can be justly accused of being obstructionists; we only ask for the privilege of being certain that change is for the better before we adopt it. In fact, often we are the ones to advocate change in the health care field. I can find nothing wrong with conservatism when life is at stake. Perhaps the medical brand of conservatism is not understood. If so, let me paraphrase a few sentences from a paper given before the Chicago Literary Society. It was entitled "The Reluctant Conservative."

> "Conservatism has been said to reflect a discriminating respect for the wisdom of one's ancestors. Few people are born respectors of this wisdom or show it in their childhood and youth, but experience tends to develop it. 'In time a man comes to realize that prevailing customs would probably not have come into use had they not once served a purpose and would probably not have endured had they ceased to serve that or some other purpose.'
> "Conservatism that is intellectually respectable boils down to the conviction that existing institutions, customs, rights, privileges and the like are a closely interrelated whole,

reflecting the experience of many generations, and by and large, they are good rather than bad.

"The thoughtful conservative, though he admires the sometimes awesome achievements of human reason as much as any liberal, is unwilling to submit himself entirely to the guidance of his own reason or the collective reasoning of his fellows. He has observed the withering effect of time on the fruits of reason—the disturbing frequency with which a scheme that appears reasonable one day seem less so the next and quite unreasonable a week or a month or a year later . . . he believes that the very faculty of discriminating should be used with discrimination."

Maybe the point I really have been trying to make today is simply this: The pharmaceutical industry believes state medical journals to be among the media by which physicians can and should be reached effectively and truthfully. It believes also that any journal that commands respect should exercise restraint which is not to be confused with censorship—over its contents so that any acclaim for leadership is earned through wise and judicious appraisal. Or in other words, as for the reluctant conservative, those responsible for the printed word should exercise the faculty of discriminating with discrimination.

Deaths

DR. ROBERT V. ACKERMAN

Dr. Robert Victor Ackerman died unexpectedly of a heart attack December 29 at Tillman while on a deer hunt with friends.

A native of Cottageville, Dr. Ackerman was 73 years old. He was graduated from the Medical College of S. C. in 1914 and had practiced in Ridgeville for the past 47 years. He was an Army veteran of World War I, having served in the Medical Corps, and was a member of the American Medical Association.

DR. SOLOMON L. ZIMMERMAN

Dr. Solomon L. Zimmerman, chief of medical service, Veterans' Administration Hospital, died unexpectedly December 8 after suffering a heart attack while en route from his residence on the hospital grounds to the hospital proper.

He was born in New York City, a son of Mrs. Ina Anna Kornbleuh Zimmerman and the late Julius Zimmerman.

Dr. Zimmerman received his BS degree from New York University in 1933 and his MD from New York University, College of Medicine in 1937. He interned in the Harlem Hospital in New York.

From 1940 to 1941, he was cardiologist with the Veterans' Administration in Hines, N. Y.

In 1941, he came to the VA hospital in Columbia as a staff physician of the medical service.

Dr. Zimmerman was commissioned a first lieutenant in the U. S. Army in 1938. In 1944, he was named major and in 1950, he was promoted to lieutenant colonel.

Although he was associated with the Veterans' Hospital he was in active service during World War II and in the Korean Conflict.

He was a member of the S. C. Medical Assoc. and the Columbia Medical Society.

Dr. Zimmerman has served as visiting physician at the Columbia Hospital since 1945.

He will be remembered among medical circles for his contributions of 23 professional medical papers published in local and national medical publications.

DR. M. E. PARRISH

Dr. Madison Edward Parrish, 58, radiologist, died December 17 after a short illness. He was born in Edgefield County on January 7, 1903, educated at the Medical College of South Carolina and majored in radiology at Duke University. He has made his home in Sumter for the past 25 years. For more than 20 years he was radiologist at Tuomey and for the past five years had served as radiologist for hospitals in Camden, Manning and Bishopville.

The 1960 year-end figures showed 132 million persons had hospital insurance, 121 million had surgical insurance, 87.5 million had regular medical insurance, 27.4 million had major medical insurance, and 42.4 million had loss of income insurance.

Insurance companies paid an estimated $3.4 billion of the 1961 benefits, said the Institute. This figure was up from the $3.1 billion paid out in 1960 and represented over three times the amount of benefits paid by insurance companies in 1951, just a decade earlier.

An estimated nine million persons aged 65 or over—approximately 53 per cent of Americans in that age category—were covered in 1961 by one or more types of health insurance according to the Health Insurance Institute.

This compares with three million "senior citizens" so protected nine years ago, said the Institute, pointing out that the percentage of aged persons with health insurance is growing at a faster rate than that of younger people.

The Kefauver Bill

STATEMENT ON S. 1552 submitted to the Senate Subcommittee on Antitrust and Monopoly, December 7, 1961

The undersigned are doctors of medicine. Each of us now teaches or has taught in a medical school in some capacity. We hold, or have held, positions of responsibility in medical societies, in hospitals, and in medical schools throughout the country. We have knowledge and experience in one or more of the many fields of medicine, and because of this we feel it necessary to make this statement.

S. 1552, now being considered by the Committee on the Judiciary of the United States Senate, contains proposed amendments to the Patent Law and other provisions which are of concern to us. We understand that these provisions are applicable only to the makers of drugs sold on prescription, and such a circumstance would undoubtedly reduce the number of new drugs available to the sick and injured. The pharmaceutical industry would be discouraged from constantly developing new agents, which have been of use in reducing the morbidity and mortality resulting from a variety of diseases and have altered the entire concept of psychiatric drug therapy.

It is our opinion that the restrictions envisaged by this Bill are detrimental to the development of new agents and thus to the health of our people. We believe the industry's current efforts should not be impaired by the proposed legislation, lest we turn back the clock of drug therapy and reduce the vigor with which the industry has found, and we believe will continue to find, valuable new medicinal agents.

It is therefore our duty to place the following additional facts in the legislative record:

1. When the prescription pharmaceutical industry was in its infancy, tuberculosis was the most common cause of death; pneumonia was the second most common cause, and the infantile diarrheas were the third. None of these are now among the first ten causes of death in this country, largely due to drug therapy. Cardiovascular deaths now rank first and deaths from cancer second. The pharmaceutical industry is playing an essential role in the development of new agents that may well be useful in treating these diseases. For many diseases we need better drugs than we now have, and the industry is cooperating with leaders in medicine to develop such drugs. Further advances in therapy will certainly come from the discovery of new agents possessing greater activity than those we now have.
2. The intelligent use of new drugs has assisted in saving countless lives during the past 30 years. Because of the economic status of some sick people, the cost of these drugs has in some cases been burdensome. But the reduction of prolonged periods of hospitalization, medical care and rehabilitation has often led to a reduction in the total cost of medical care.
3. Many of the most important new drugs have been discovered and put into use through the efforts of the American pharmaceutical industry. The research on those discovered outside the industry's laboratories has often been financed by the industry. Extensive animal and clinical tests have been conducted by qualified pharmacologists and physicians often at the industry's expense. After the drugs have been officially approved for human use, the industry makes sure they are widely available in every part of the nation and fully informs doctors as to the potentialities and problems involved in their use.
4. These efforts involve substantial risks to the industry. Even after discovery, many of these drugs are not found worthy of marketing. We are advised that only one out of some 2800 chemical substances investigated by the industry becomes a marketable drug. We believe that the industry needs adequate financial incentives if it is to continue taking such risks.
5. For many diseases, we now have drugs of considerable effectiveness. Many of these drugs are far from perfect; there is plenty of room for better ones. For many other diseases, effective drugs have not as yet been found. If the present pace of drug discovery can be maintained or accelerated, we can hope for more progress in the next 20 years than we have had in the last 20. The doctors of 1981 will probably regard the drugs of 1961 to be just as outmoded as we regard the drugs of 1941 today.
6. In the main, we believe that the industry has the support of the ablest people in the medical profession. We believe we are justified in continuing this support of an industry which has done so much to improve the health of our people. In our judgment, it would be a grave mistake to make any major change in the conditions under which this industry functions. While there have been occasional instances of digressions that perhaps were not in the best interest of medicine, these exceptions have in the main been so rare that we do not think they deserve the action contemplated by the proposed legislation.
7. The industry's leaders assert, and we believe rightly, that the patent law provisions of S. 1552 would have the effect of materially changing the conditions under which the industry operates and would thus act as a deterrent to discovery and growth. We have found the executive and scientific staffs of the leading prescription drug firms to be men of probity devoted to advancing the art and science of medicine in the public interest. Some of us have been at one time or another scientific consultants to members of the industry. If there is even a reasonable chance that the industry's progress will be impeded, then the proposed legislation will do far more harm than any possible good. It is for these reasons that we urge the Congress not to enact this legislation.

The above statement was prepared by a committee headed by I. S. Ravdin, M. D., and including Warren H. Cole, M. D., Michael E. DeBakey, M. D., John R. Heller, M. D., Chester S. Keefer, M. D., and Howard A. Rusk, M. D.

WHAT THE MEDICAL PROFESSION EXPECTS OF ITS COLLECTION REPRESENTATIVE

HENRY C. HEINS, JR.

CHARLESTON, S. C.

Most physicians are aware that our profession is under scrutiny. We are concerned about the increase in malpractice suits, about threats of encroachment by labor and government. We are deluged with suggestions from psychologists to be less business like, more friendly with our patients. These motivation experts state that the patients want togetherness with their doctors. They want the disease explained to them so that they feel that they are participating in the treatment. They want a doctor who is a friendly first-naming sort with no pretense of a halo.

I personally do not concur with this line of thinking. We can never put across the idea that its fun to go to the doctor. People don't want to make the healing process a social occasion. The doctor should show by his demeanor and grave concern that he takes illness seriously. He should give the impression that he knows more than the patient about how to deal with it. The patient wants to feel that he can lean on the physicians' superior knowledge. He prefers a decent sense of distance between the healer and the healed. Of course, this can be overdone—the physician can be too business like and be compared to the operator of a supermarket.

The public's concept of adequate and proper medical care is changing. There are many reasons for this, of course. One is the avidity with which all news media respond to medical news both good and bad. Perhaps, too, in the light of this interest, the traditional professional reserve and total devotion of the physician to his strictly professional duties has made it appear that he resists any change in his environment.

Today, health or the lack of it—which we call disease—is no longer entirely a personal thing. Health is everybody's problem and everybody's business—and there is getting to be an astronomical number of "everybodies."

Whether we approve or not, the fact remains that all people have developed an almost insatiable appetite for medical information. While medicine used to be entirely a private enterprise, it is changing to the character of public utility. Medicine used to be a private concession operated by doctors for doctors. It is now becoming a public utility operated by doctors in cooperation with other segments of society.

Obviously, from all this preamble, the doctor is no longer on the so called pedestal—that lofty perch held by the old family physician. The recent trend toward further specialization of medicine, increased medical knowledge of the patient, and the charlatans about the fringe of medicine (naturopath, etc.) are further reasons for this present state of affairs. Yet it is a state in which the patient is living longer in a more comfortable condition.

There is also a changing concept of our population toward hospitalization. The introduction and growth of hospital insurance has created a health conscious America. People no longer dread going to the hospital; in fact, some of us spend more time talking people out of going to the hospital than we do in making arrangements to admit them to the hospital. It is estimated that over 120 million people now have some type of health insurance. Eight percent of our population is now over age 65 and this small group uses approximately 20% of all general hospital days. This problem of caring for our senior citizens is basic in health financing. It can and must be both acknowledged and solved.

But what has all this to do with our collection representative? Since the doctor's family has to buy groceries and usually expects to do so with money earned by his abilities, it is apparent he should attempt to collect as many accounts owed as possible. Figures from the U. S. Dept. of Commerce show that the age of an account determines its value. After six months for instance, each "account receivable" dollar is worth only 67 cents; after 1 year, only 45 cents; after two years, 23 cents; after three years 15 cents and after 5 years 1 cent.

If an account is not paid because of a misunderstanding which leaves the patient feeling he has been overcharged, or if a patient is in unusual financial straits which he is too embarrassed to explain to the physician, or if a person is a known "dead beat" who owes numerous doctors and businesses and whose account is sure to become a bad debt—the physician should know.

Dr. DeTar, a past president of the American Academy of General Practice, in 1955 did a survey of what 140 physicians thought of collection agencies. Approximately one-third of the physicians so sampled were critical of and did not use collection agencies. It seems to be the general impression of the group not using collection representatives that the physician should consider credit in terms of ethics as well as business. They stated it is better to have a patient's good will and understanding than a paid up account and no patient. However, the majority of physicians think agencies are effective, otherwise they would not use them. Some physicians escape the high cost of maintaining old accounts simply by writing them off without giving them to an agency. They write off 25-100% of their overdue accounts.

Other physicians feel that the medical profession

should have more control over collection agencies. They feel it takes just one bad agency to give the whole profession a black eye. Most physicians feel responsible for tactics used by an agency and are very mindful of the effect on public relations. I, personally, do not feel our Medical Society should operate its own credit and collection agency.

The doctor doesn't expect and he shouldn't expect miracles from collection agencies. Some studies show that he may realize only 10 cents on a dollar. These accounts are worked thoroughly before turning them over to a collector. The returns may be mediocre compared to the total value of the accounts but they are better than nothing—which is probably what the doctor would have gotten had he not used the agency.

How does a doctor go about picking the correct or so-called correct collection agency? The wrong kind of outfit can lose both money and patients for him. The seven following factors are important for a physician choosing his collection representative:

1. Does the agency operate locally?
2. Does the agency have a special interest in professional accounts?
3. Does it charge as much as 33-50% on the amount collected?
4. Will the agency serve the physician without requiring him to sign a contract?
5. Is the agency used and endorsed by other local physicians?
6. Are its procedures of a kind the physician would approve?
7. Does the collection representative permit the physician to make all final decisions on his accounts?

While these seven factors should be considered in choosing his collection representative I feel the physician should meet certain criteria in fairness to the collection agency.

1. He should give all necessary information about every account turned over.
2. He should give a full explanation of any fee that needs clarification.
3. He should stop billing the patient once the account is handed over to the collection agency.
4. He should report any payments made directly to him immediately.

Which bills should be turned over to the collection agency? If the doctor sends an unpaid account to the agency too soon he wastes money and risks antagonism of the desultory patient, but if he waits too long, the bill becomes more difficult and more expensive to collect.

Actually the age of the account is only one criterion for judging whether it should be turned over to the agency. Most physicians agree that the so-called proper time, if there is a proper time to turn a delinquent account to the collection representative, is at five to six months. This account is considered ripe for turning over to the collector if the physician had done the following:

1. Sent the bill to the person who is responsible for paying it.
2. Seen to it that the patient understands all charges.
3. Seen that the debtor has the ability to pay.
4. Sent bills promptly and regularly.
5. Tried to trace the patient if he has moved.
6. Made reasonably sure that there is no chance of of a malpractice suit.

How long should the physician try to collect the small unpaid accounts, say $5.00 or less. The doctor should send no more than 3 bills and 3 letters to collect any amount under $5.00. By using even the least expensive billing methods it costs the doctor at least $1.00 to bill a patient 5 times, so if the amount owed is $2.00 we lose 50% during the process. If $5.00 is owed we lose 20% by sending 5 statements. It is better economics to turn small accounts over to the collector while there is a 50-50 chance of collecting and let the collector absorb part of the loss if he doesn't collect it!

Something that we lack here in South Carolina that our neighbors have up in North Carolina is a committee to study the various collection agencies. In fact, the Medical Society of North Carolina had an exhibit at a recent AMA meeting supervised by Dr. W. Howard Wilson, whom I think most of you know. This exhibit spelled out a guide for MD's who were thinking of employing collection agencies. While speaking of Dr. Wilson I might quote from his report on medical credit bureaus which was given at the N. C. Medical Society meeting in Asheville in 1958. In a summary of his committee report he listed some advantages and disadvantages of credit bureaus which I think may sum all this up very nicely. The advantages were:

1. The physician can be relieved of the burden of an account after exhausting personal collection efforts have failed.
2. Charged off or neglected accounts rarely produce collections, while the collection agency might get some results.
3. In the case of a substantial number of debtors, doctors are reminded that the practice of medicine involves a business factor.
4. A credit bureau puts subsequent dealings with delinquent patients on a sounder basis.
5. It rids the physicians' office staff of the responsibility of dealing with delinquents.
6. It rids the physician of some undesirable patients who become offended by reminders of their delinquency.

Some disadvantages are:

1. To some degree it exposes physician-patient affairs to semi-public perusal, which is distasteful.
2. It might suggest mercenary practices and commercialization and thereby lessen the intangible dignity and prestige of the profession.
3. It might offend debtors who have been inadvertently negligent of their obligation.

4. It might be the subject for argument whether the practice of medicine should have features of big business or whether it is strictly and purely a ministerial service in which financial gains are purely incidental and secondary.

A LETTER FROM DR. MARION SIMS

267 Madison Ave., New York
June 19, 1880

Dr. O. B. Mayer

My dear Doctor

I am very unhappy about sending your niece home without any material improvement and almost just as she was when she came here.

She complains all the time of a sore place that never could be reached exactly. At first I thought I had found it. On passing a sound into the uterine cavity as soon as the point struck the fundus she moved suddenly away and said that was the spot. You will remember that there was complete stenosis of the cervix uteri. The os was almost like a pinhead and the canal exceedingly narrow and very gristly. I incised the cervix posteriorly and opened the canal sufficiently. She has menstruated a little better since, but her old pain still continues. On examining the cavity of the uterus again with the sound I found the same tender spot in the fundus as before the operation of incision. I then dilated the neck of the uterus with a sponge tent and cauterized the cavity of the uterus. She was no better from this. In due time I again dilated the neck with another sponge tent and then curetted the fundus of the uterus and when it touches the fundus it does not produce the exquisite agonizing suffering that it did previous to this rather heroic sort of treatment. Notwithstanding this the pain that she always complained of was persistent. I had searched for it in vain and never had been able to localize it.

When she first mentioned it to me I supposed that it was in the ovary on the right side but I could not satisfy my mind on that point.

Only two or three weeks ago I hit upon the plan of drawing the uterus right up behind the inner face of the symphysis pubes by the bi-manual method. When the uterus was drawn into this position, as a matter of course the ovary was brought into reach and while the uterus was held in this way I was able to reach the right ovary and to press it between the fingers in the cul de sac of the vagina and the hand externally and thus obtain unmistakable evidence of the ovaries being the seat of the constant pain that has lately worried her existence. I have made this examination repeatedly and am now satisfied that it is the right ovary and nothing else that is the seat of pain. The ovaries do not seem to be hypertrophied nor have they any abnormal adhesions. They are easily moved in any direction and this very facility of movement has all along been an obstacle to locating the point of suffering. Now it becomes a question, if I am right in this view, and I believe I am, what course shall we pursue? I send her home to you for counsel and advice and for rest from the perturbating treatment which I have been obliged to adopt. Of course we must do what we have been doing all the time—give her tonics and all the nourishment possible to improve her general condition. In a half jocular way I have threatened to send her to Philadelphia to my friend Dr. Weir Mitchell to get a course of his forced alimentation, and seriously I think it would be a very good thing to do. Besides a nutritious diet I have nothing else to suggest but electricity and the mildest sort of counterirritation, still I must frankly say that these hold out no great prospect of a permanent cure. If she should not in a reasonable time improve greatly I would have no hesitation in recommending the extirpation of the offending organ. Batty's operation consists in the removal of both ovaries to bring about the menopause. This is not necessary in her case. She has no general nervous symptoms that demand anything of the sort. She has simply ovaralgia and I would propose to extirpate that organ just as we would extirpate a tooth for the removal of neuralgia due to its diseased condition. All the ovaries that I have removed in Batty's operation where there was persistent pain and suffering have been diseased, that is there was cystic degeneration or some organic change of the stroma of the organ. As the suffering has existed so long in this case although it is not above normal size I fear that there is such a change in its organic structure that her sufferings cannot be relieved by any ordinary course of treatment. She has a great horror of the operation—not so much of its danger as of the loss of an organ which it involves, but I told her that with one ovary she will menstruate as regularly and naturally as if she had two and that with one ovary, if she should ever marry she will as certainly have offspring as with two. So far as the dangers of the operation are concerned they are now by the antiseptic method reduced to a minimum. I have never had a case in which it has been so difficult to arrive at a correct diagnosis and never one in which my sympathies have been more deeply enlisted. I shall be most happy to do anything I can for the relief of this brave, patient, long suffering and lovely child. I leave town tomorrow to be absent a few weeks but will return early in September to resume my labors for another year. When you have leisure please let me hear from you. Your letter will be forwarded to me. Believe me my dear Dr. Mayer

Most faithfully & truly yours
J. Marion Sims

Book Reviews

PROBLEMS OF PULMONARY CIRCULATION, Ciba Foundation Study Group No. 8. Edited by A. V. S. deReuck and Maeve O'Connor. Little, Brown and Company, Boston, 1961. Price $2.50.

This small volume, 96 pages, is a collection of papers and subsequent discussion, presented at a one day study group supported by Ciba Limited, Basle. Participants in the conference included authorities in the field of cardiopulmonary physiology from Great Britain as well as from Scandinavia, Germany and the United States. The papers presented were six in number and along with accompanying discussion included pulmonary blood flow and its nervous control, pulmonary hypertension, gas exchange and its relation to pulmonary blood flow, as well as other problems relating to pulmonary circulation. The material should be of particular interest to cardiologists and other physicians and investigators interested in cardiopulmonary disease as it presents current thinking of pulmonary physiologists with regard to pulmonary circulatory dynamics.

Kelly McKee, M. D.

MAYO CLINIC DIET MANUAL, Third Edition. W. B. Saunders Co., Philadelphia, Pa. 1961. $5.50.

This is a new edition of information on diets and diet procedures prepared by the Committee on Dietetics at the Mayo Clinic primarily for guidance of physicians, dietitians and nurses at the Clinic, revised by its authors to maintain it as an up-to-date reference. It is a cardboard back loose-leaf volume of better than two hundred pages with a great variety of diets and diet information. Standard hospital diets of various types showing protein, fat, carbohydrate, mineral and vitamin content are outlined as well as special diets for the many medical and surgical disorders requiring dietary restrictions or additions. Also included in the appendix are tables with a great variety of information helpful in diet preparation. This is a well organized and complete manual useful for students, house officers and physicians, as well as dietitians.

Kelly McKee, M. D.

HEALTH EDUCATION, A GUIDE FOR TEACHERS AND A TEXT FOR TEACHER EDUCATION, by Bernice R. Moss, Ed. D.; Warren H. Southworth, and John Lester Reichart, M. D.; published by the National Education Association of the United States; 429 pages; $5.00.

The American Medical Association and the National Education Association have collaborated to produce in one volume a complete text for teachers who are learning to teach health on any level—from kindergarten through college.

Of inestimable value to the school man are the chapters on "Developing the Curriculum" and the chapter on "Materials and Resources." The exhaustive selected references at the end of each chapter serve as a fine basis for a librarian interested in setting up or completing a library section on health at any educational level.

The value of this book is clearly demonstrated by the fact that upon publication it was immediately adopted as the text for the extension courses in health education for teachers by the University of South Carolina.

Other books in the series, which are a joint effort of the AMA and the NEA, are *Healthful School Living* and *School Health Services.*

John E. Gibbs, Principal
Julian Mitchell Elementary School

PRACTICAL PEDIATRIC DERMATOLOGY, by Morris Leider. Second edition. C. V. Mosby Company. St. Louis. 1961. pp. 437. Price $13.75.

This book avoids the usual approach of covering the pediatric aspects of dermatology and is, as its name applies, a practical exposition of dermatology in the young. It is well written and well organized and I found it delightfully explicit on patient and parent counselling.

The description of how to handle the scratching atopic child and the harassed parents and relatives is worth the price of the book.

There are a number of excellent differential diagnostic tables and a separate formulary, easy to find because of its distinctive green color, covering the one hundred and one most useful topical applications commonly used. The author's decision to use common every day objects for size comparison of skin lesions is definitely preferable to using the more scientific metric system. Here again, practicality is stressed.

The author gives detailed directions as to managing each condition, outlining local and general treatment in often striking terms, such as "necessary brutality, stuck-on crusts, etc". One slight fault in his tendency to use too many long words such as "disadvised," "worsening," "wonderment," and "internistic evaluation".

This book is recommended highly as a practical and useful text, in any physicians office.

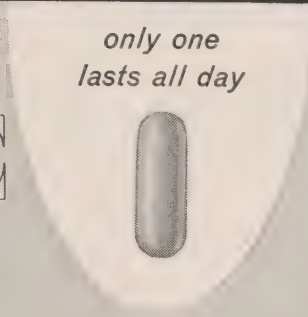
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Research in the Service of Medicine

MANAGEMENT OF HYPERTENSIVE DISEASE. Joseph C. Edwards, C. V. Mosby Company, St. Louis, 1960, 439 pages, 1622 references, price $15.00.

This book covers more than the therapeutic management of those with hypertensive disease. There are chapters on the natural history, diagnosis, and etiology of hypertension, on heart disease, and on the electrocardiogram in hypertension, and on many other aspects of the problem. Of necessity, most of these topics must be briefly covered in a book of this size. More attention is given to the problem of therapy and especially to drug therapy. Discussion of the indications for the use of a great number of antihypertensive agents, tables of recommended dosages, a chapter on the pharmacology and side effects of the drugs are all given the scope that they deserve. Comments on emotional factors and their control, the use of sedatives, and detailed diets are all presented fully. Too much space is alloted to long case reports illustrating problems in the diagnosis and treatment of individuals with rare or surgically correctible forms of hypertension.

The author achieves his stated purpose of creating a guide to the practical management of hypertension. It should be of great use to those sincerely interested in the control of hypertensive disease who realize that the treatment of this complex entity demands more than the irregular dispensing of various amounts of medication. Sixty pages of bibliography should be more than enough to satisfy those who wish to pursue the subject further.

C. M. Smythe, M. D.

ADRENERGIC MECHANISMS. Ciba Foundation. Little, Brown and Company, Boston. 632 pp. 1960. $12.50.

Sir Henry Dale has given the opening address and served as chairman in this seminar involving 75 investigators from several countries. Essentially the chief interest is that of chemical transmission of nervous impulses. The transmitters, their precursors, activators, inhibitors, etc. include particularly the catechol amines, high energy phosphate compounds, serotonin, LSD, bretylium, TM10, guanethidine, and the monoamine oxidase inhibitors. Chemical conversion processes in the body are particularly emphasized as are also storage and depletion changes. These experimental inquiries appear to be approaching a rational explanation of essential hypertension although the objective is hardly mentioned in the discussions. Despite the intricate studies of mechanisms centering around the actions of adrenaline and noradrenaline no attention is given to the fact that these compounds profoundly increase the pumping force of the human heart. The fact that such a clinically important effect is wholly subordinated to the twitch of the cat's nictitating membrane, for instance, indicates the theoretical nature of this particular symposium. For those engaged in such specialized endeavors, this volume is highly valuable and it can make interesting reading to anyone with a casual, peripheral interest in the field.

R. P. Walton

MEDICAL PHYSIOLOGY, 2nd ed., Arthur C. Guyton, M. D., W. B. Saunders Co., Philadelphia, 1181 pages, 1961. $15.00.

This textbook presents in detail the regulatory systems of the human body as a functioning organism. The basic data of function and general structure are expended into their application to states of disease. The book is essentially a treatise on pathophysiology. Specific disturbances encountered in the patient are related to findings in all the basic sciences applicable, as well as in particular clinical interests or methods. This quite broad interpretation of the field of physiology is most striking. It illustrates the great crossing over of departmental lines now present in medical institutions in various areas of activity. This reviewer is among those who strongly believe that the basic scientist should be a member of the team in handling certain difficult problems in a sick patient.

The chapters are well arranged in logical sequence for ready reference to organ systems. The final three sections on metabolism, hormones and radiation include an extensive view not restricted by more conventional limits of the field of physiology. A list of references to recent literature is appended to each chapter. This book contains a wealth of diverse information of value to student and physician.

Fred Kredel

OUTLINE OF PATHOLOGY by Mahold and Bolden. W. B. Saunders Co., Philadelphia, 1960. $4.75.

This book is precisely what its title would indicate, an outline of Pathology. It does not attempt to include any startling new material and does not touch upon controversial issues. This is certainly a most elementary outline of pathologic processes and probably of little value to a serious student of disease. It would probably aid "the neophyte to study and the graduate recall", but it is certainly limited to this endeavor.

H. R. P-T.

SYNOPSIS OF PATHOLOGY. 5th edition. W. A. D. Anderson. The C. V. Mosby Co., St. Louis, 1960. $9.25.

The only possible criticism of this most comprehensive synopsis is that it may be so complete and satisfying as to preclude the student's utilization of standard texts and auxillary reading. Every sentence is factual and in a volume of 876 pages a great deal of information may obviously be available. It is lucidly written and well organized. It should be of great benefit to students of the undergraduate and postgraduate level; particularly, those who need to refresh themselves as to the facts of one of the foundation sciences of medical practice. It is highly recommended.

H. R. P-T.

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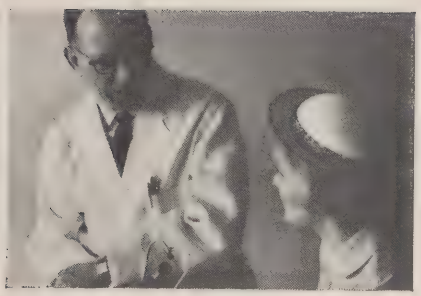
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Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



"cramps" don't cramp her style...

when you prescribe

Trancoprin®

Aspirin.....(5 grains) 300 mg.
Trancopal® (brand of chlormezanone).....50 mg.

Trancoprin is more than a simple analgesic: It deals with cramping pains in three ways. Besides dimming pain perception, Trancoprin, through its tranquilizing action, reduces anxiety and raises the tolerance for discomfort. And, against the spasm caused by pain which, in turn, produces more pain, Trancoprin exerts its skeletal muscle relaxant action.

Trancoprin is exceptionally safe to use: Fewer than two and a half per cent of patients can be expected to have any side effects, and these are of a minor nature.

Available in bottles of 100 tablets. The usual dosage in dysmenorrhea is 2 tablets 3 or 4 times daily.

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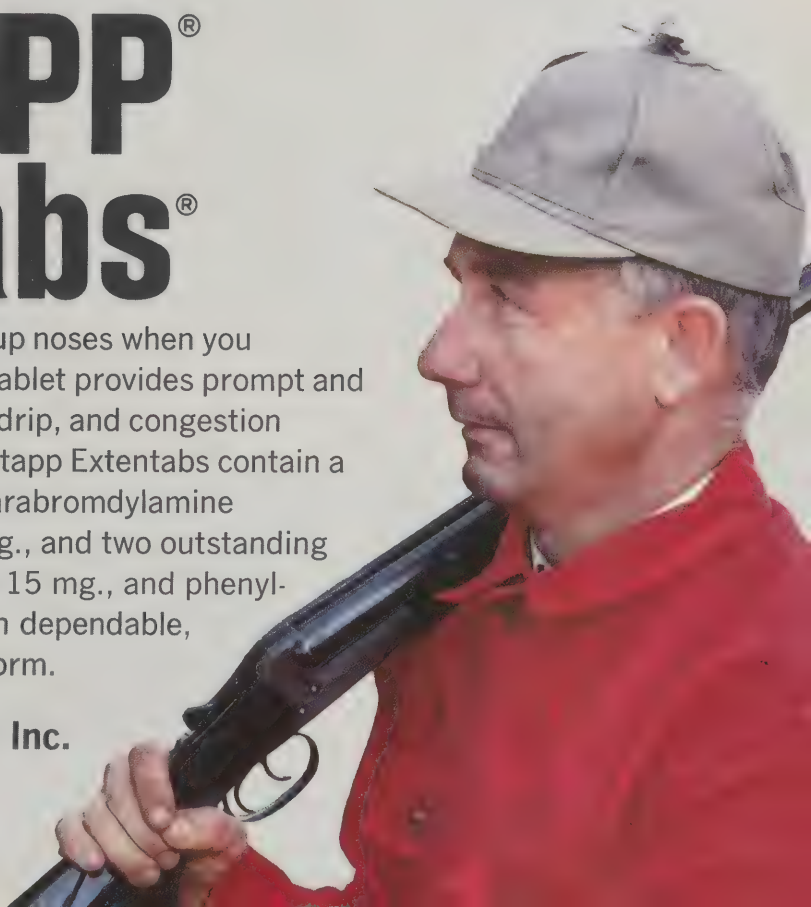
OPEN SEASON ON CLOGGED NOSES

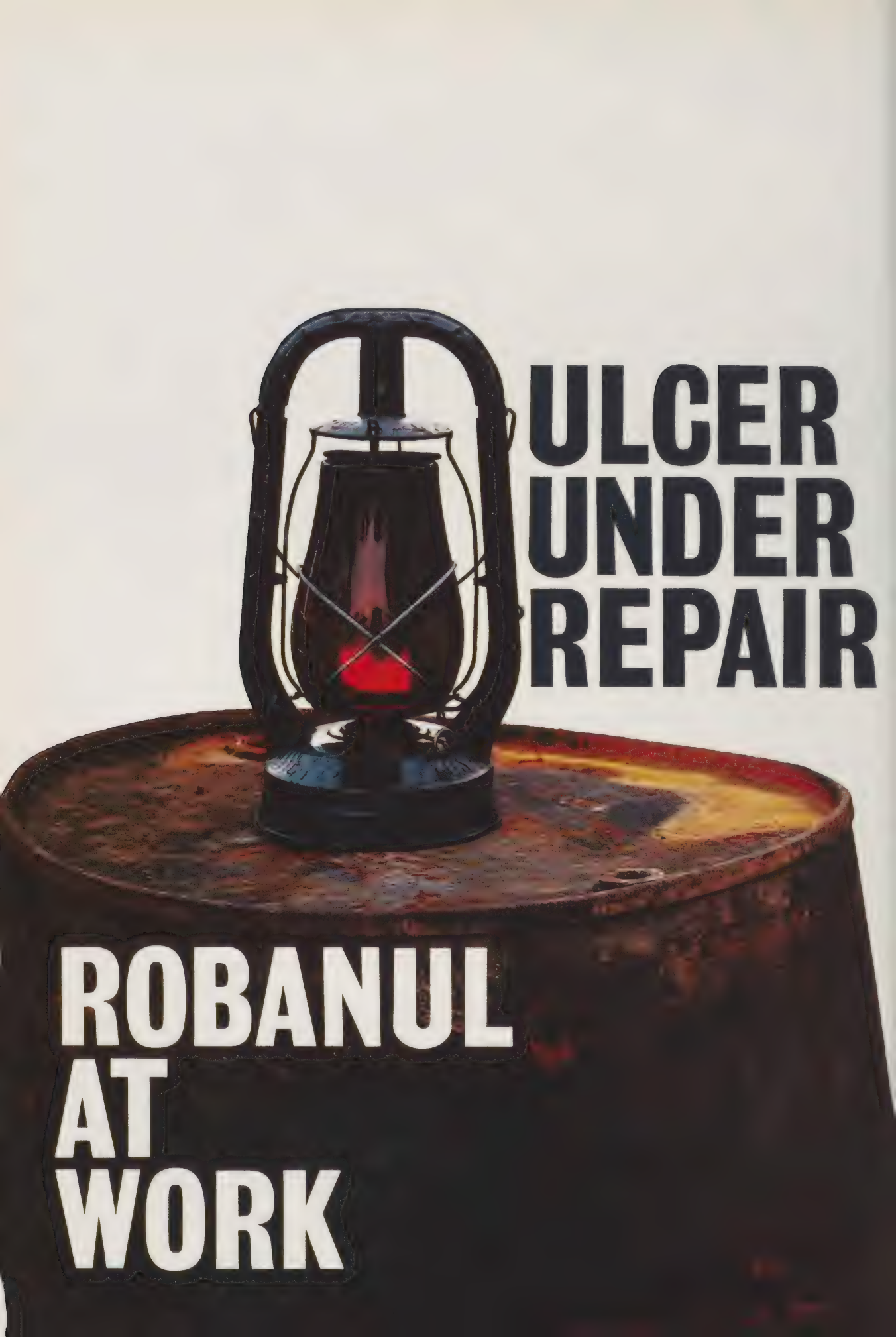
in sinusitis, colds, U.R.I.,
10-12 hours
clear breathing on 1 tablet

DIMETAPP® Extentabs®

It's always Open Season on stopped-up noses when you prescribe Dimetapp Extentabs. One tablet provides prompt and prolonged relief from the stuffiness, drip, and congestion of upper respiratory infections. Dimetapp Extentabs contain a proven antihistamine, Dimetane® [parabromdylamine (brompheniramine) maleate]—12 mg., and two outstanding decongestants, phenylephrine HCl—15 mg., and phenyl-propanolamine HCl—15 mg.... all in dependable, long-acting (10-12 hours) Extentab form.

A. H. Robins Company, Inc.
Richmond, Va.




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New

Robanul™ signals a major improvement in duodenal ulcer therapy

From Robins research comes Robanul (generically, Glycopyrrolate), first of the "rigid-ring" anticholinergics, representing what may well be the most important advance in anticholinergic chemistry in a decade.

Clinically, both Robanul and Robanul-PH (with phenobarbital) have demonstrated a remarkable ability to provide within 90 minutes—and maintain for 6 to 10 hours—those nearly ideal pharmacologic healing conditions that mean prompt relief of ulcer pain and a successful recovery of your ulcer patient.

There are always important questions about any new therapeutic agent. Below are answers to some of the common ones asked about Robanul:

ROBANUL™

Glycopyrrolate (Robins), 1.0 mg. per tablet (U.S. Pat. No. 2,956,062)

ROBANUL™-PH

Robanul with phenobarbital, 16.2 mg. per tablet

First of all, what does "rigid-ring" mean?

Briefly, this: it describes the use of a fixed pyrrolidine pentagon, or rigid ring, which guarantees a constant 2-carbon distance between reactive parts of the molecule. In line with the "receptor site" concept of the mechanism of action of anticholinergics, this almost inflexible molecule is theoretically more likely to "fit" only certain receptor sites.

Theories are all right, but is Robanul really more selective?

Yes! Evidence of its selectivity can be seen by the surprising lack of typical secondary anticholinergic effects (dry mouth, blurred vision, etc.) that occur at the effective dosage level of 1 to 4 mg. a day. Out of 499 duodenal and gastric ulcer patients treated at this level in investigative studies, only 4.4% had complaints of moderate to severe effects.

How is it for reducing gastric acid?

One investigator[1a] found that a 2 mg. dose of Robanul lowered acid secretion 73% in one hour (compared to a basal-hour period) and 84% in two. A 4 mg. dose dropped secretion over 94% in one hour and 97% in two!

What about acidity, or concentration of acid?

In one study, glycopyrrolate produced significant suppression of pH to 4.5 or higher in 5 of 5 duodenal ulcer patients given a 4 mg. dose, 7 of 8 patients given 2 mg., and 4 of 5 patients given 1 mg.[1b]

Will Robanul depress gastric hypermotility?

In another study[2] with six subjects Robanul decreased gastric motility in every patient. Within 40 minutes after the administration of 2 mg. of Robanul, the frequency of gastric antral contractions decreased from 1 every 24 seconds to only 1 every 2½ minutes. Young and Sun[1c] found a similar effect. Moreover, their results in 7 patients indicated that Robanul, in a dose of 2 mg., did not produce delay in gastric emptying or intestinal transit.

What's the best dosage schedule for Robanul?

It should be adjusted for each patient, and this is where Robanul offers another big advantage. Its "titratability" is unmatched among anticholinergic agents. Robanul's potency makes possible a recommended starting dose of only one milligram t.i.d. Yet its selectivity usually permits much leeway for dosage adjustment upward as necessary, to achieve the most effective dose level for each patient while maintaining a low incidence of undesirable effects on other organ systems.

Is there anything else Robanul does for peptic ulcer?

Much more! For instance, 2 mg. cuts pepsin production about 50% in two hours; 4 mg., about 65%.[1a]...There is evidence that Robanul combats hormonal aspects of gastric secretions as well as vagal in many patients... ...Its activity lasts long enough to reduce acid secretion all night long.[3]...Many ulcer patients have remarked about its fast relief of pain....

One last question: Why not prescribe Robanul for your next duodenal ulcer patient and see for yourself just exactly how effective it is?

References: 1. From the New York Academy of Sciences, Conference on Peptic Ulcer, Oct., 1961. (a) H. C. Moeller. (b) D. C. H. Sun. (c) R. Young and D. C. H. Sun. **2.** W. C. Breidenbach: Investigative clinical report, March, 1961. **3.** I. A. Feder: Investigative clinical report, May, 1961.

Additional information upon request.

A. H. Robins Company, Inc., Richmond 20, Va.



"All the world's a stage..
And one man in his time
plays many parts,
His acts being seven ages..."*

*As You Like It, Act II, Sc. 7

through all seven ages of man

VISTARIL®

effective anxiety control
with a wide margin of safety

in the "frantic forties"—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

In each of these areas, VISTARIL is often effective alone or as an adjunct to other therapy. For example, in his series of 67 patients, King[1] found that 62 showed remission of anxiety, tension, nervousness and insomnia, as well as alleviation of symptoms associated with various functional and psychophysiological disturbances. He concludes that VISTARIL is well suited for use in the practice of internal medicine.

In the emergent situation, VISTARIL, administered parenterally, is a valuable aid to the physician in managing patients who escape psychic conflict via alcohol. According to Weiner and Bockman,[2] who obtained beneficial results in 81% of 175 patients studied, hydroxyzine (VISTARIL) may well be considered a tranquilizer of choice in the management of the acutely agitated alcoholic.

1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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HYDROXYZINE PAMOATE
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See "In Brief" on the next page.

IN BRIEF VISTARIL®

VISTARIL, hydroxyzine pamoate (oral) and hydroxyzine hydrochloride (parenteral solution), is a calming agent unrelated chemically to phenothiazine, reserpine, and meprobamate.

VISTARIL acts rapidly in the symptomatic treatment of a variety of neuroses and other emotional disturbances manifested by anxiety, apprehension, or fear—whether occurring alone or complicating a physical illness. The versatility of VISTARIL in clinical indications is matched by wide patient range and a complete complement of dosage forms. The calmative effect of VISTARIL does not usually impair discrimination. No toxicity has been reported with the use of VISTARIL at the recommended dosage, and it has a remarkable record of freedom from adverse reactions.

INDICATIONS: VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

ADMINISTRATION AND DOSAGE: Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

SUPPLIED: VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

More detailed professional information available on request.

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CASE 263

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(Excerpt of letter from
Mrs. M. G., San Francisco, California. Name available on request.)



Sealy®

You know that chronic lower back trouble is not a simple matter. The Posturepedic mattress, then, cannot be a "cure." But patients who have tried Posturepedic and doctors who use it, too, know it *can help*. They find the firm, level support Posturepedic gives to spine and muscular system in back and limbs promotes normal, healthful sleep among *all* persons.

The Sealy Posturepedic, as you undoubtedly know, is designed in cooperation with leading orthopedic surgeons. We believe your investigation and *personal use* will firmly convince you of its distinctive benefits and, we would hope, merit your valued recommendation. Why not prove it to yourself by taking advantage of this liberal professional discount plan now?

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This is a saving of $39 per set over the regular retail price for innerspring mattress and matching foundation. Limit: one full or two twin size sets. MAIL TO: Sealy Mattress Co., 666 N. Lake Shore Dr., Chicago 11

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Posturepedic in Foam Rubber $159.00 per *set* (add state tax)		$120.00

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True S-U-S-T-A-I-N-E-D Action in Steroid Therapy

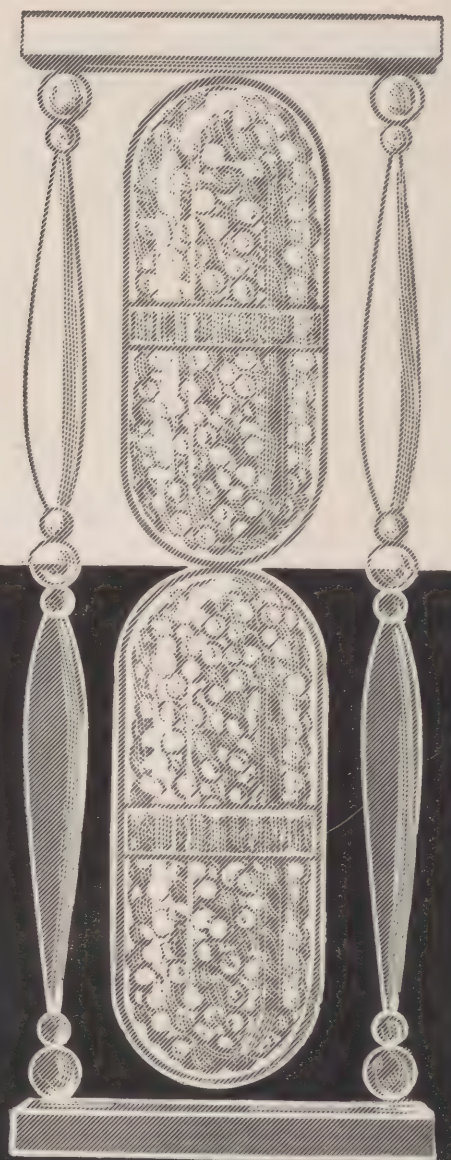
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Now, for the first time, the benefits of steroid therapy are enhanced by sustained release PREDLON PELSULES.

USES: Rheumatoid arthritis, disseminated lupus erythematosus, allergic diseases, and other conditions where the use of steroids is indicated.

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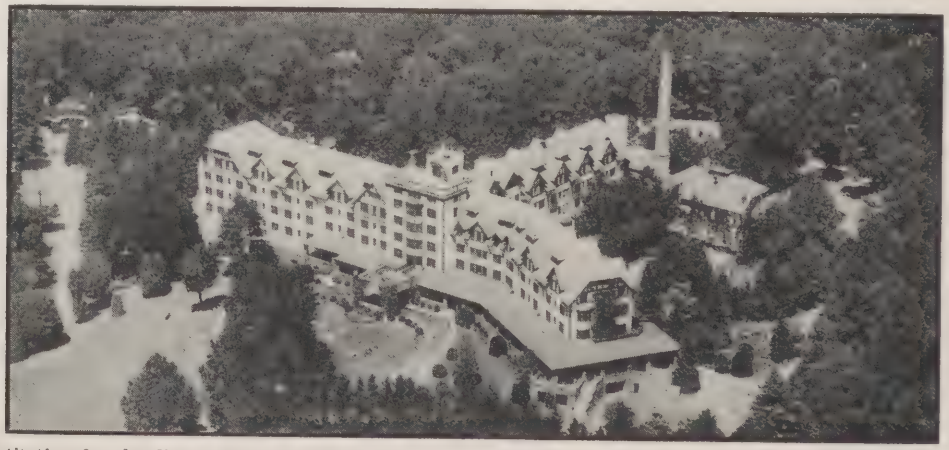


Coca-Cola, too, is compatible with a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy ... brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

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If you had to make your own children's multivitamins

...chances are you'd try to make them very much like our new Vi-Daylin® Chewable with Entrapped Flavor. Entrapped Flavor means a better tasting chewable children's multivitamin; one with no vitamin aftertaste. Here's why: 1. We coat all the vitamins in a digestible film that does not dissolve until it reaches the gastrointestinal tract. This means that unpleasant strong vitamin tastes are not released in the mouth, but in the g-i tract where they are most quickly absorbed. 2. We make certain that every Vi-Daylin Chewable tablet tastes citrus sweet and good to every patient, everytime; we coat the flavoring oils in each tablet in a water soluble film. This film dissolves immediately in the mouth, releasing the full bouquet of our citrus-candy flavoring agents. Now you know why little patients always taste the flavor, never the vitamins, when you prescribe new Vi-Daylin Chewable. And the formula's all you'd expect, with reasonable amounts of A & D. Taste test them yourself and you'll prescribe **VI-DAYLIN CHEWABLE** regularly and soon.

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Profile of a multivitamin



New Vi-Daylin Chewable —with entrapped flavor

New Formula

In recognition of recent medical thinking, we've reduced the vitamin D in our formula from 20 mcg. (800 units) to 10 mcg. (400 units). At the same time, we've increased the vitamin C content from 40 mg. to 50 mg. per tablet and per 5-cc. lemon-candy teaspoonful.

All Other Elements Remain at Their Previous Level.

Vitamin A (3000 units)	0.9 mg.
Thiamine Mononitrate	1.5 mg.
Riboflavin	1.2 mg.
Cobalamin (B_{12})	3 mcg.
Nicotinamide	10 mg.
Pyridoxine Hydrochloride	1 mg.

New Low Price

In quantities of 100 tablets our new Chewable costs less than 4¢ a tablet and the normal dosage is one tablet daily. No financial hardship for your patients when you prescribe or recommend Vi-Daylin.

New Shape, New Color, New Bottle

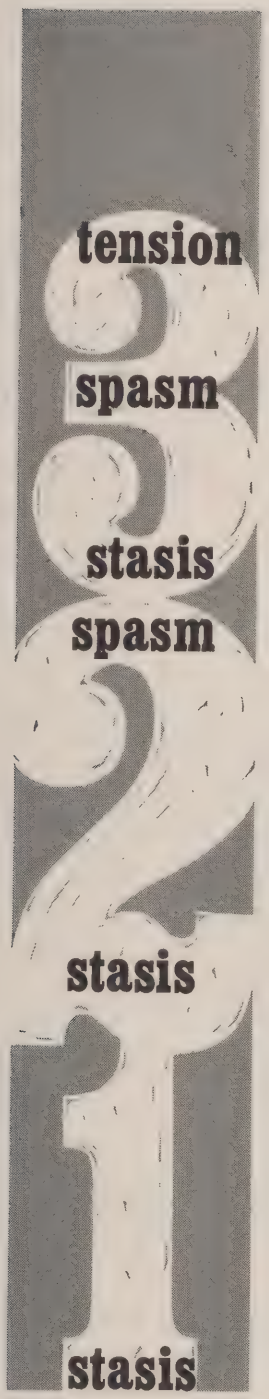
New Vi-Daylin Chewable tablets are football shaped. This shape got a high degree of acceptance in our taste-tests and seems to have an intrinsic interest for children. The orange color ties in with the mild, sweet citrus flavor. And the wide-mouthed new bottle looks handsome on the table.

Taste-Test New Vi-Daylin Chewable Yourself

Won't you taste-test new Vi-Daylin Chewable multivitamins yourself? We're certain you'll be pleasantly surprised at their sweet good taste. They're the candy-flavored multivitamins with *entrapped flavor* . . . little folks taste the candy flavor, never the vitamins.

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Hydrocholeretic • Antispasmodic • Sedative...to reduce *TENSION* and anxiety-induced dysfunction of G.I. and biliary tracts...and also relieve both smooth-muscle *spasm* and biliary/intestinal *stasis*

butabarbital sodium ..... 15 mg. (¼ gr.)
(Warning—may be habit forming)
dehydrocholic acid, AMES .....250 mg. (3¾ gr.)
belladonna extract ..... 10 mg. (⅙ gr.)

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Hydrocholeretic—Antispasmodic...to relax *SPASM* of smooth muscle of G.I. tract and sphincter of Oddi...and also counteract biliary/intestinal *stasis*

dehydrocholic acid, AMES .....250 mg. (3¾ gr.)
belladonna extract ..... 10 mg. (⅙ gr.)

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dehydrocholic acid, AMES .....250 mg. (3¾ gr.)

Average adult dose: 1 or, if necessary, 2 tablets three times daily.

Side effects: DECHOLIN by itself, or as an ingredient, may cause transitory diarrhea. Belladonna in DECHOLIN with Belladonna and DECHOLIN-BB may cause blurred vision and dryness of mouth.

Contraindications: Biliary tract obstruction, acute hepatitis, and (for DECHOLIN with Belladonna and DECHOLIN-BB) glaucoma.

Precautions: Periodically check patients on DECHOLIN with Belladonna and DECHOLIN-BB for increased intraocular pressure. Also observe patients on DECHOLIN-BB for evidence of barbiturate habituation or addiction, and warn drivers against any risk of drowsiness.

Available: DECHOLIN-BB, in bottles of 100 tablets; DECHOLIN with Belladonna and DECHOLIN, in bottles of 100 and 500.

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Can we measure the patient's comfort?

The physician can measure the basal metabolic rate by means of oxygen consumption. But he has no instrument—no objective test—for measuring comfort.

For this, he must depend upon his own powers of observation and the patient's own description of how he feels.

Because these are, admittedly, subjective criteria, the validity of results hinges entirely on the experience and objectivity of the investigators involved.

Such well-qualified clinicians have reported that a new corticosteroid developed in the research laboratories of Upjohn actually raises the level of relief obtainable with this type of therapy.

This difference cannot be "proved." It must be seen. And the only practical way for you to do this is to evaluate this new drug critically in your own practice. Please do, at your first opportunity. We are confident that you will be glad you did.

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Alphadrol*

Each tablet contains Alphadrol (fluprednisolone) 0.75 mg. or 1.5 mg.
Supplied in bottles of 25 and 100.

The anti-inflammatory activity of Alphadrol is comparable to the best effects obtained in current practice. Results obtained with Alphadrol have been such as to warrant classifying it among the most efficient steroids now available.

More than twice as potent as prednisolone, Alphadrol exhibits no new or bizarre side effects. Salt retention, edema or hypertension, potassium loss, anorexia, muscle weakness or muscle wasting, excessive appetite, abdominal cramping, or increased abdominal girth have not been a problem.

Indications and effects
The benefits of Alphadrol (anti-inflammatory, antiallergic, antirheumatic, antileukemic, antihemolytic) are indicated in acute rheumatic carditis, rheumatoid arthritis, asthma, hay fever and allergic disorders, dermatoses, blood dyscrasias, and ocular inflammatory disease involving the posterior segment.

Precautions and contraindications
Patients on Alphadrol will usually experience dramatic relief without developing such possible steroid side effects as gastrointestinal intolerance, weight gain or weight loss, edema, hypertension, acne or emotional imbalance.

As in all corticotherapy, however, there are certain precautions to be observed. The presence of diabetes, osteoporosis, chronic psychotic reactions, predisposition to thrombophlebitis, hypertension, congestive heart failure, renal insufficiency, or active tuberculosis necessitates careful control in the use of steroids. Like all corticosteroids, Alphadrol is contraindicated in patients with arrested tuberculosis, peptic ulcer, acute psychoses, Cushing's syndrome, herpes simplex keratitis, vaccinia, or varicella.

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February, 1962

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Kalamazoo, Michigan
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Theragran®

SQUIBB VITAMINS FOR THERAPY

For your patients with infections or other illnesses who need therapeutic vitamin support. Each Theragran supplies the essential vitamins in truly therapeutic amounts:

Vitamin A	25,000 U.S.P. Units
Vitamin D	1,000 U.S.P. Units
Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Vitamin C	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B_{12}	5 mcg.

SQUIBB *Squibb Quality—the Priceless Ingredient*

'Theragran'® is a Squibb trademark

"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

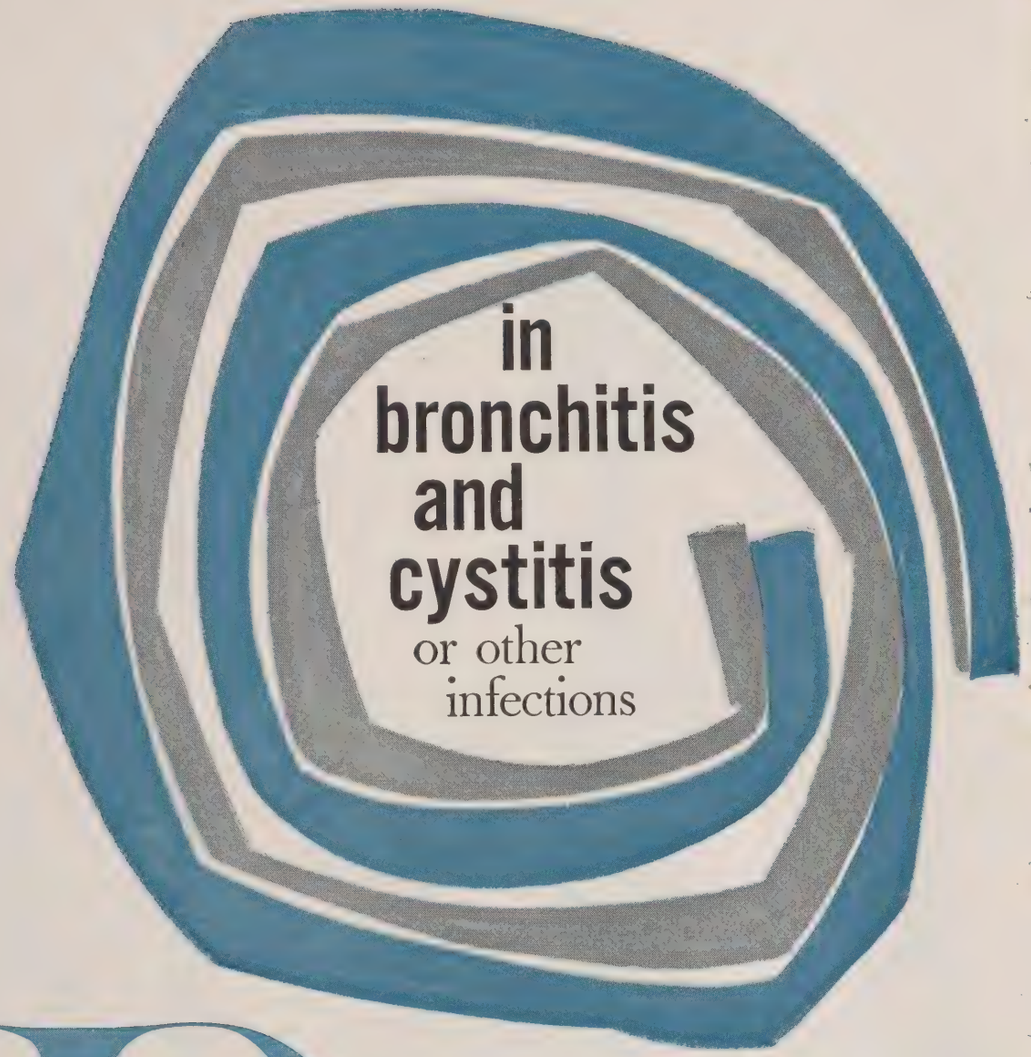
digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported In: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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Recent medical literature[1-27]—adding to an already massive bibliography—continues to document the effectiveness of well-tolerated Terramycin in respiratory and other infections.

Recent bibliography: 1. A.M.A. Council on Drugs, New and Nonofficial Drugs 1961, Philadelphia, Lippincott, 1961, pp. 142-147. **2.** Beckman, H.: The Year Book of Drug Therapy, Chicago, Yr. Bk. Pub., 1961, p. 271. **3.** Eastman, N. J., and Hellman, L. M.: Williams Obstetrics, ed. 12, New York, Appleton-Century-Crofts, 1961, pp. 845-1035. **4.** Keefer, C. S., in Modell, W.: Drugs of Choice 1960-1961, St. Louis, Mosby, 1960, pp. 141, 146, 147. **5.** Huang, N. N.: J. Pediat. 59:512, 1961. **6.** Smith, R. C. F.: Brit. J. Clin. Practice 15:345, 1961. **7.** Asay, L. D., and Koch, R.: New England J. Med. 262:1062, 1960. **8.** Berry, D. G., et al.: Lancet 1:137, 1960. **9.** Osol, A., et al.: The Dispensatory of the United States of America, ed. 25, Philadelphia, Lippincott, 1960, pp. 953, 1556. **10.** Adams, A. R. D.: Brit. M. J. 1:1639, 1960. **11.** Jung, R. C., and Carrera, G. M.: Dis. Colon & Rectum 3:313, 1960. **12.** De Lamater, J. N.: Am. J. Gastroenterol. 34:130, 1960. **13.** Stewart, W. H., et al., in Kelley, V. C.: Brenneman-McQuarrie-Kelley Practice of Pediatrics, Maryland, Prior, 1960, vol. II, chap. 5, p. 19. **14.** Wellman, W. E., and Herrell, W. E., in Kelley, V. C.: Brenneman-McQuarrie-Kelley Practice of Pediatrics, Maryland, Prior, 1960, vol. I, chap. 44, p. 13. **15.** Wenckert, A., and Robertson, B.: Acta chir. scandinav. 120:79, 1960. **16.** Alstead, S.: Dilling's Clinical Pharmacology, ed. 20, London, Cassell, 1960, p. 462. **17.** Grover, F. W.: Texas J. Med. 57:355, 1961. **18.** Gardiner, W. P., and Gomila, R. R., Jr.: Scientific Exhibit, Venereal Disease Seminar, U.S. Public Health Service, Feb. 28-Mar. 3, 1961. **19.** Jacques, A. A., and Fuchs; V. H.: J. Louisiana M. Soc. 113:200, 1961. **20.** Nathan, L. A.: Scientific Exhibit, 15th Clinical Meet., A.M.A., Denver, Col., Nov. 26-30, 1961. **21.** Ullman, A.: Delaware M. J. 32:97, 1960. **22.** Lamphier, T. A.: Scientific Exhibit, New York State M. Soc. Meet., New York, May 7-13, 1960. **23.** Freier, A.: Paper presented at Michigan Soc. Obst. & Gynec., Detroit, May 3, 1961. **24.** Logan, K. M.: Scientific Exhibit, Ann. Meet., Ohio Acad. Gen. Practice, Cincinnati, Sept. 13-14, 1961. **25.** Altemeier, W. A., and Wulsin, J. H. (A.M.A. Council on Drugs Report): J.A.M.A. 173:527, 1960. **26.** Krol, W. J.: J. Abdom. Surg. 3:78, 1961. **27.** Potempa, J.: Med. Klin. 56:352, 1961.

In Brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated. For complete dosage, administration, and precaution information, read package insert before using.

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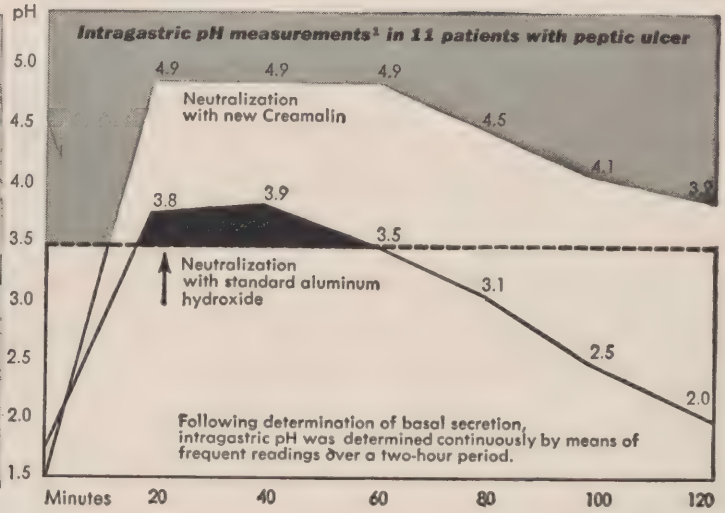
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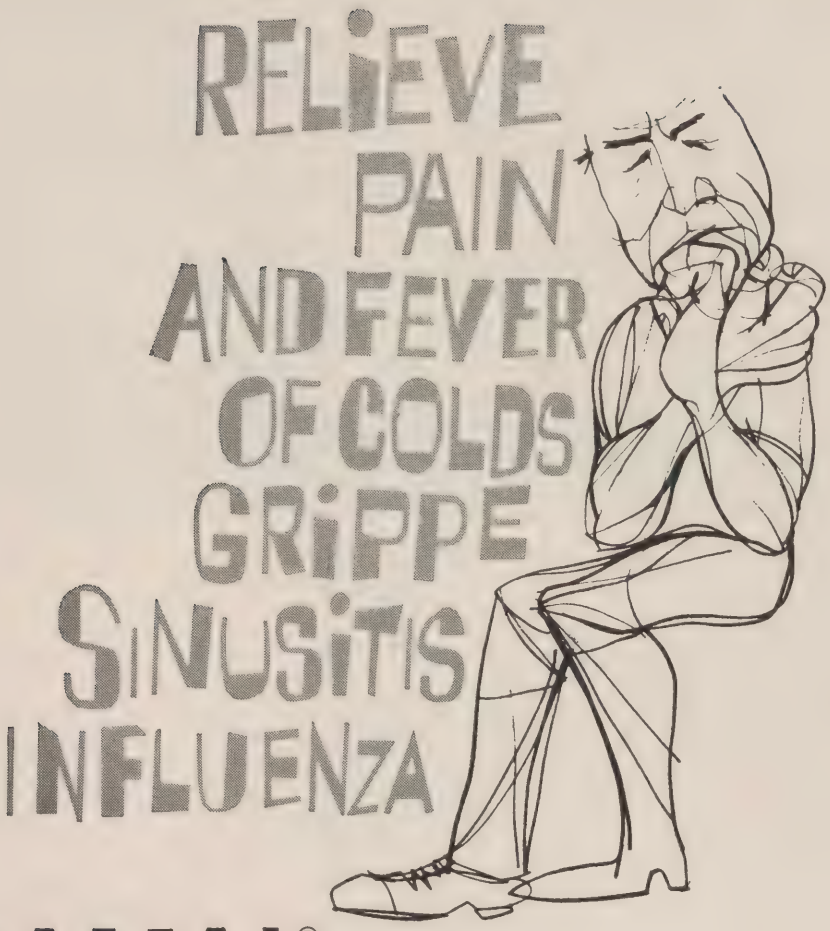
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References: **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr. ; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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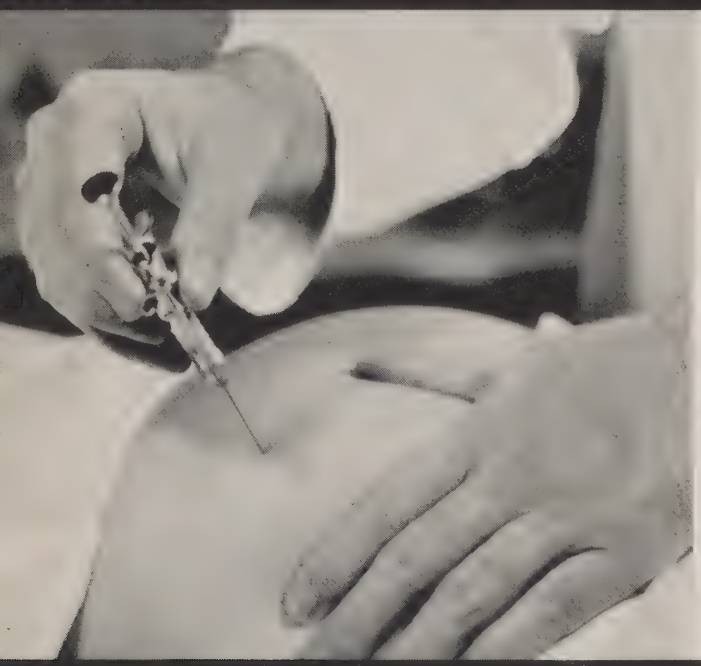
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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. **2.** J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. **3.** J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. **4.** W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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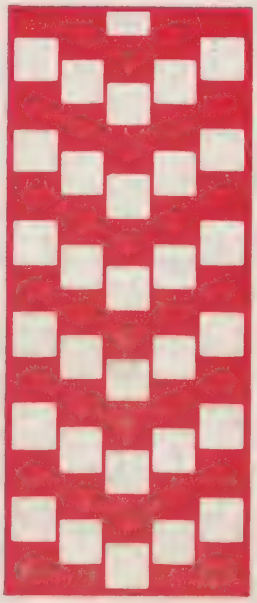
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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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ORIGINAL ARTICLES

Correlation of Hemometrics and Hemodynamics in the Human—*Gilbert B. Bradham, M. D., J. Manly Stallworth, M. D. and Barbara Threatt, M. D.* ---- 77
Gunshot Wound of the Gravid Uterus—Report of a Case—*William H. White, Jr., M. D.* ---- 82
Problems in Gallbladder Diseases—*Henry Donato, M. D.* ---- 85
Constitutional Hepatic Dysfunction (Gilbert's Disease)—A Case Report—*E. Walter Masters, M. D.* ---- 89

MEDICAL COLLEGE CLINICS

Electrocardiogram of the Month—Left Intraventricular Block—*Dale Groom, M. D.* ---- 91
Dermatological Don'ts—Pityriasis Rosea—*Kathleen Riley, M. D.* ---- 92

EDITORIALS

New Medical College President ---- 95
English Medicine ---- 95
Think or Drink ---- 96

FEATURES

President's Page ---- 94
Program for Annual Meeting ---- 96
News ---- 97
Civil Defense ---- 102
Correspondence ---- 103
Public Relations ---- 104
Deaths ---- 107
Basic Facts About the AMA ---- 108
Book Reviews ---- 111

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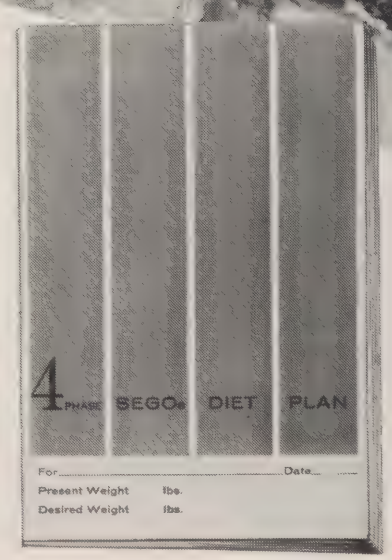
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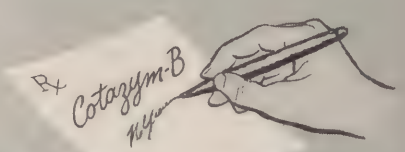
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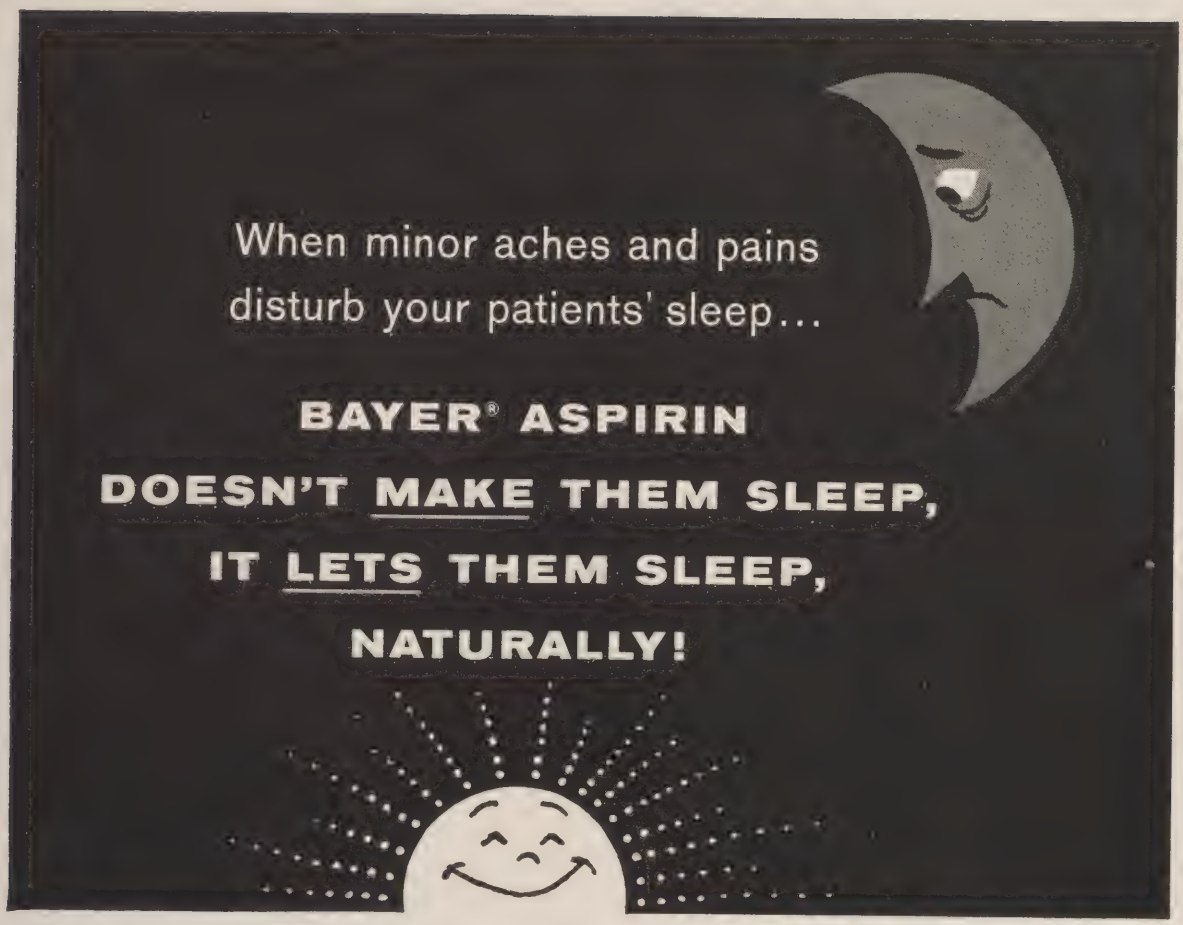
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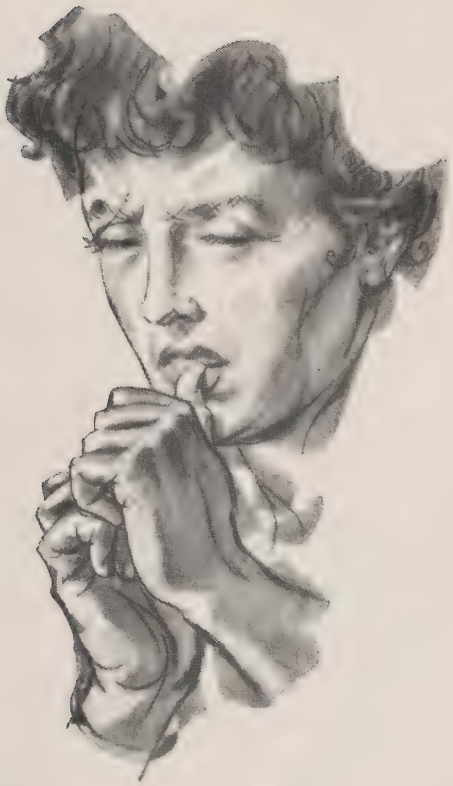
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The Journal
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VOLUME 58 March, 1962 NUMBER 3

CORRELATION OF HEMOMETRICS AND HEMODYNAMICS IN THE HUMAN*

GILBERT B. BRADHAM, M. D.**
J. MANLY STALLWORTH, M. D.***
BARBARA THREATT, M. D.****
Charleston, S. C.

The attempts at defining the bounds of the vascular space have been arduous and profuse.[1-8, 5-13, 14-24] An excellent review of the many methods by which these attempts have been made is given by Gregerson and Rawson.[11] The majority of the methods have used the dilution principle, which under the more recent modifications, has resulted in an accuracy of 3 to 5 percent. It is now generally agreed that the volume of the blood is best measured with the use of radioisotopes bound either to red cells or to one of the plasma proteins. One may actually measure the red cells and the plasma with appropriate isotopes at the same time.[19] With advancing accuracy in handling these isotopes, one may now observe that the tool which he is using to measure the total blood is also measuring the manner in which that blood is behaving.

One manner of behavior of blood has led to the concept of an "effective circulating blood volume", a concept which implies that not all of the blood is dynamic, that some portion of it is at least remaining temporarily dormant, not serving its function of liaison between the body cell and the eventual environment of that cell.

It is the intention of this study to investigate the role of blood volume measurement in defining the concept of "effective circulation". Blood volume measurements were made in normal and variously ill humans using isotope tagged red cells for measuring red cell volume and using isotope tagged albumin for measuring plasma volume.

The red cell volume (RCV), measured directly, added to the plasma volume (PV), also measured directly, made up the total blood volume (TBV) in these patients. The red cell volume as compared to the total blood volume would give a total body hematocrit (TBH). The total body hematocrit is therefore an expression of the relation of all of the body's red cells to all of the body's plasma. In any completely mixed blood sample this figure should correspond to the one usually obtained by centrifuging blood and simply visualizing

* Supported by the John A. Hartford Foundation.
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*** Assistant Professor in Surgery, M. C. of S. C., Charleston, S. C.
**** At present Interne, Wayne County Hospital, Eloise, Michigan.

the ratio of cells to plasma in the centrifuge tube. This latter hematocrit when obtained from a large blood vessel is termed the large vessel hematocrit (LVH).

If the total body hematocrit and the large vessel hematocrit were exactly equal, the ratio between them would be 1.0 (unity). This ratio is obtained by dividing the total body hematocrit (TBH) by the large vessel hematocrit (TBH/LVH). Moore[15] states that this hematocrit ratio varies between .88 and .92 in normal humans when the total body hematocrit is obtained with use of dye dilution techniques. He states that use of isotope dilution technique might increase this ratio towards unity.

If there were found a greater proportion of cells to plasma in the large vessels in the body than was found in the total survey of the body's blood vessels, then one might well assume that in the small blood vessels, the arterioles, capillary beds, venules, there necessarily existed a relative paucity of cells to plasma.

With these definitions and concepts in mind, measurements of red cell volume and of plasma volume were made in ten healthy young men. The total body hematocrit-large vessel hematocrit ratio averaged unity. Measurements were made in six patients with peripheral vascular disorders. These patients were arbitrarily termed "mildly ill". The hematocrit ratio again averaged unity. Measurements were made in four surgical patients easily classified as "seriously ill", who, though severely toxic due to sepsis, yet maintained normal blood pressure. Their hematocrit ratios averaged 0.80. This ratio dropped to an average of 0.73 in two other patients with vasomotor collapse. Figure 5 shows these relationships.

Methods

Red cell volume was measured by tagging the patient's blood in a special ACD bottle prepared comcercially by Abbott* with 75 to 100 microcuries of chromium 51 as sodium chromate. The process of incorporation of the chromium into the red cell was arrested with ascorbic acid, then 20 ml. of this blood was reinjected into the patient using a calibrated syringe. After allowing 10 to 20 minutes mixing time, a sample of the patient's blood and a sample of the tagged blood-ACD solution were compared for radio-

* Abbott Laboratories, Oak Ridge, Tennessee.

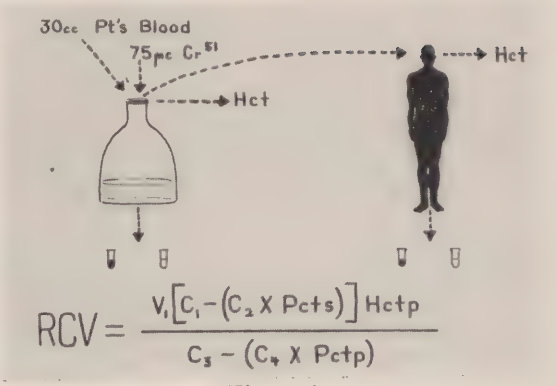


Figure 1

A schematic representation of red cell volume determination. The transfer of the tagged blood to the patient via syringe is measured with extreme care.

activity contained within the cells. Figure 1 shows this process schematically.

As soon as the blood sample was drawn for red cell volume, the plasma volume was measured by using tracer quantities of radioiodinated human serum albumin (RISA*). Twelve to fifteen microcuries of RISA were added to 50 ml. of normal saline. Using the same syringe, 20 ml. of this prepared solution was added into a 2,000 ml. volumetric flask, and 20 ml. were injected into the patient. Again, allowing time for mixing, a sample of blood from the patient was obtained and centrifuged. An equal quantity of the standard and plasma were counted for radioactivity. Figure 2 shows this in a schematic fashion.

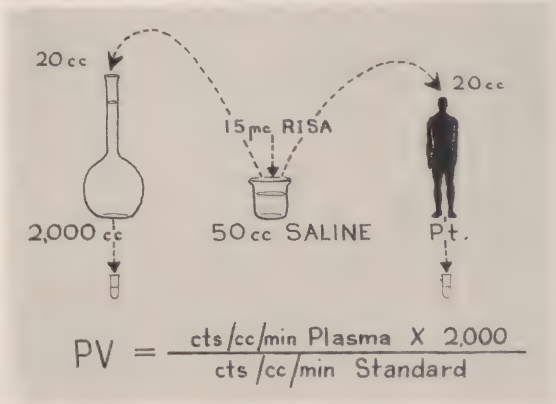


Figure 2

A schematic representation of plasma volume determination. The same syringe is used to inject into the flask and into the patient.

Hematocrits were determined by centrifugation techniques including the standard Wintrobe method and the current microhematocrit method. Hematocrits were also measured by isotope techniques. The latter consisted of counting equal volumes of whole blood and plasma which contained RISA. It is therefore

* Abbott Laboratories, Oak Ridge, Tennessee.

obvious that the difference in count is a function of the volume of the red cells which do not incorporate the tagged protein. Using these several techniques, accurate correction could be made for "trapped plasma" in the centrifuge tube and in all instances where hematocrit was used, this correction was made.

Again, total body hematocrit (TBH) was obtained by dividing the directly measured red cell volume by the directly measured total blood volume. The hematocrit ratio is obtained by dividing total body hematocrit by peripheral large vessel hematocrit (LVH). Figure 3 shows the hematocrit relationship.

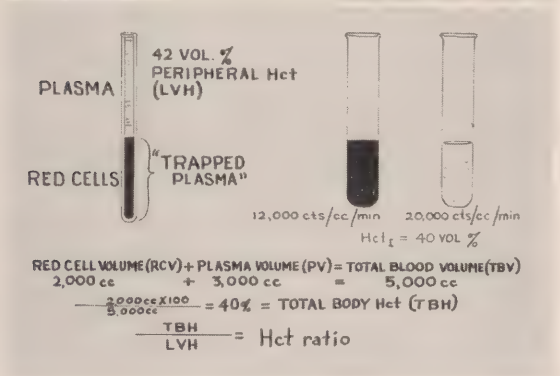


Figure 3

The above shows the various hematocrit relationships. In the conventional Wintrobe tube plasma is "trapped" between red cells. In the isotope hematocrit on the right, equal volumes of blood and plasma containing tagged albumin are counted and the comparison of counts indicates the space occupied by the red cells.

Results

The results from this study are essentially those depicted in the two graphs, Figures 4 and 5. The red cell volume in all groups is shown in Figure 4 as the stippled area. This is a relationship of milliliters per kilogram of body weight. The red cell volume is seen to correlate closely with body weight in kilograms, there being little variation in the normal and mildly ill group. Plasma volume is the clear area of the graph in Figure 4 which has been added to the red cell volume to produce total blood volume in milliliters per kilogram body weight.

From this graph, the red cell volume in the normal individual and in patients with mild peripheral vascular disease appears constantly correlated with total body weight. Plasma volume in these two conditions seems more closely associated with an estimation of lean body mass (clinical estimation of nonfat weight).

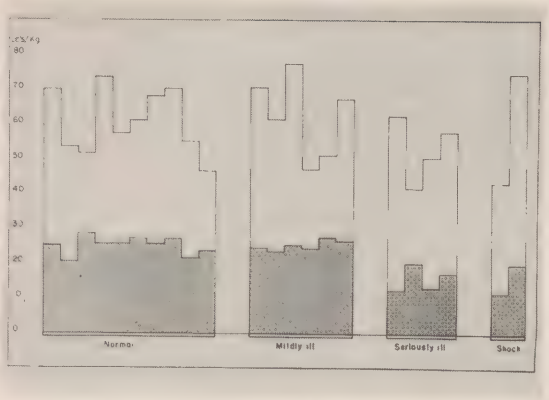


Figure 4

This graph represents the relationship of the red cell mass (stippled) and plasma volume measured separately and added, to body weight in kg. Note the constancy of red cell mass in the first two groups. The plasma volume is more variable and appears dependent on total body water. The first normal patient was a tall muscular nonfatty individual, the second was short and relatively obese, etc.

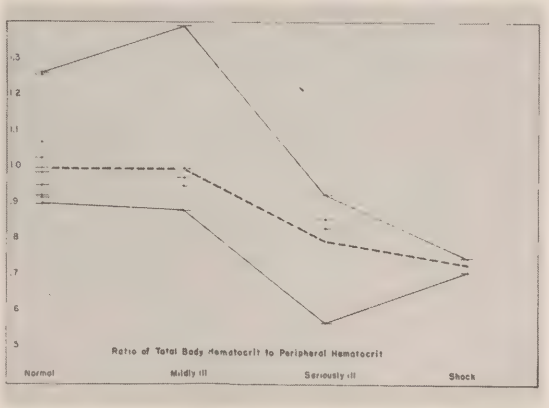


Figure 5

This graph represents the two hematocrits under discussion and their relationship to each other in the variously ill groups. Although recognizably not statistically significant, it tends to indicate a trend of decreasing hematocrit ratio volume in shock.

In the seriously ill patients, there is seen great variation in these compartments that does not necessarily compare with any standard. In Figure 5 the hematocrit ratio in the normal and peripheral vascular patients varied between 0.90 and 1.37 with an average of slightly over 1.0 in both groups. This ratio dropped to an average of 0.80 in the seriously ill patients and to 0.73 in the patients showing peripheral vascular collapse.

Discussion

If one would assume reasonable accuracy in the measurements described, and there being a departure of total body hematocrit from large vessel hematocrit, then one may well further assume a relative paucity of red cells in the small vessels of the body during acute serious illness, particularly when blood pressure is not well maintained.

If this latter assumption is true, then there are at least two immediate clinical considerations; (1) that fewer red cells are present at the tissue level to perform work, and (2) that any blood volume measurement using only a direct measurement of either plasma or red cells alone in combination with peripheral hematocrit, may lead to serious error in proper treatment of an acutely ill patient. In one of the critically ill patients, S. G., the total body hematocrit and the large vessel hematocrit were noted to be widely separated. The red cell volume was 900 ml. The plasma volume was 2456 ml., producing a total body hematocrit of 26.8 volumes percent, and yet the large vessel hematocrit (in this patient both vena caval and anticubital veins were used) was 37.9 volumes percent. Had only plasma volume and large vessel hematocrit been used to assess red cell volume (or total blood volume), a figure of 1603 ml. would have been obtained. The difference is assessing a red cell mass at 1600 ml. and at 900 ml. is made even more apparent if it is realized that to make up this deficit of 700 ml. of red blood cells, 2000 ml. of stored bank blood (hematocrit averaging 35 volumes percent) would need to be transfused.

The evidence here presented suggests a disproportion of cells and plasma at the tissue level, more simply stated, one sees that he is actually measuring a larger plasma space than the large vessel hematocrit would suggest. If one entertains the idea that plasma leakage would provide the answer to this puzzle, he is hard put to state this quantity leakage in the amount of time the actual measurement took place. It appears more reasonable to postulate those concepts offered by others regarding the pathophysiology of the distal vascular bed. Knisley's[18] evidence that red cell deposition may occur on the dependent portion of blood vessels during shock lends direct visual evidence to an altered hemodynamic physiology. The work of Brill and Shoemaker[4] shows the presence of red cell agglutination in the hepatic sinusoids and splanchnic bed. Shu Chien[20] produced this picture experimentally. Shires[19] showed comparable results. Chaplin[6] illustrated varying hematocrits in small vessels with constant large vessel hematocrit.

With the evidences cited, it appears with increasing stress to the organism, particularly with normal blood pressure not being maintained, there is a tendency towards disproportionate red cell—plasma at the distal vascular bed, there is a loss of "effective circulating red cells", rather than more simply a loss of "effective circulating blood volume".

Whether or not this altered hemodynamic situation interferes seriously with cellular respiration and exchange of metabolites is conjectural at this point. It appears that such conjecture is reasonable.

Summary

Plasma volume and red cell volume are measured by described techniques in 22 individuals, 6 of whom were seriously ill.

There is little difference between correlation of red cell mass and total body weight, and correlation of red cell mass and lean body mass.

Plasma volume is best associated with lean body mass.

A disparity may appear between peripheral hematocrit and total body hematocrit. In normaly and mildly ill individuals this disparity approaches unity and does not usually fall below 90 percent of unity. In seriously ill individuals, this ratio may fall to 75 to 85 percent of unity.

This altered hematocrit ratio may represent a changing ratio of effective red cells to effective plasma in the small vessels of the body.

In seriously ill patients, a normal peripheral hematocrit may lend a false sense of security, endangering that patient's chance for recovery.

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Venereal disease in adolescents—L. Watt. Brit. Med. J.—8:858 (Sept. 30) 1961.

The author describes a comparative study of venereal infections found in boys and girls, 15 to 19 years of age, reporting to a venereal disease clinic. Only patients with early syphilis and acute gonorrhea were included. The study indicates trends and not the incidence of disease in Britain. Of 1,227 male patients treated in 1938 for venereal infections, 39 (3.1%) were adolescents. In 1960, of 1,123 male patients treated, adolescents numbered 56 (4.9%. Of 229 female patients treated in 1938 for venereal infections, 16 (6.9%) were adolescents. In 1960, of 329 female patients treated, adolescents numbered 78 (23.7%). Adolescents are forming an increased and perhaps increasing proportion of individuals treated for venereal infections. The increase is most marked in females. General factors influencing this increase are described but cannot by themselves be held entirely responsible. Increasing promiscuity may play a major part. The increase is not due to an increase in the numbers at risk. Further similar studies are suggested to determine the extent of the problem.

GUNSHOT WOUND OF THE GRAVID UTERUS

REPORT OF A CASE

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In our present day society, gunshot wounds of the abdomen occur quite frequently and the mortality is always high. However, the available medical literature affords us very little indication of the relatively high incidence of this accident.

Kobak and Hurwitz[2] in a review of the literature in 1954 presented 33 cases. Earlier in the same year, Wright *et al*[3] published an article which presented an additional 5 cases to the literature. Carter[4] in 1955 reported a single case and in 1960 Beattie and Daly[5] added the latest case report to the literature. Undoubtedly, many more cases occur than are reported, and we feel that this is unfortunate, as injuries such as this stimulate much interest and concern among surgeons and pediatricians as well as the obstetrician-gynecologist, especially in that two lives instead of one are involved. With this thought in mind, we would like to add another case report to the medical literature, the detailed account of which follows.

Case Report

A 21-year-old married colored female Gravida two, Para two, no abortion was admitted by ambulance stretcher to the emergency room of the Greenville General Hospital at 5:45 P. M. on July 9, 1960 after having been shot approximately 10 minutes earlier. The expectant mother had been struck in the abdomen by a .22 caliber pistol bullet about 5:35 P. M. on the same day, as she stepped from the door of the Negro U. S. O. Club.

On arrival in the emergency room, the patient was found to be alert, with a blood pressure of 140/80 mm. Hg and no evident signs of shock. Intravenous fluids were started immediately and the patient typed and cross-matched for 1500 ml. of blood. A Levine tube was inserted and routine blood work and urinalysis obtained following the insertion of a Foley catheter. The gastric contents and urine showed no evidence of blood. Physical examination showed a bullet wound in the left upper quadrant of the abdomen about 4 cm. above and to the left of the umbilicus, but no exit wound could be found. Heart and lungs were negative and the patient appeared to be approximately 7 months pregnant. Fetal heart beats were audible in the right lower quadrant of the abdomen at a rate of 160 per minute. Because the patient was not felt to be in any immediate danger, an AP and lateral x-ray film of the abdomen was obtained. These films were reported as showing a single fetus in a cephalic presentation with the estimated fetal age being approximately six months. There was a bullet lying anteriorly in the right upper quadrant of the abdomen which appeared to lie within the uterine wall. There were also a few globular tubules of gas present in the fundus of the uterus suggesting the presence of air secondary to perforation of the uterus by the bullet.

Routine blood work showed a WBC of 9,650 with segs 54 per cent and lymphs 46 per cent. The hemoglobin was 11.5 gms. and the urinalysis was negative.

Approximately 2 hours after her admission to the hospital, an exploratory laparotomy was begun under spinal anesthesia. The abdomen was opened through a left para-median incision and the uterus examined. The entrance and exit wounds of the bullet were noted in the upper portion of the uterus between the broad ligaments, the wounds being 4 to 5 cm. apart. There was considerable bleeding from the exit wound in the right uterine wall and the uterus appeared approximately the size of a 7½ months gestation. At this point, the question as to whether to perform a cesarean section or to only debride and repair the uterine wounds was considered. It was felt that the bullet had probably pierced the placental site and therefore, it was decided at this time to perform a cesarean section. A low transverse cervical cesarean section was done with delivery of a viable 2 pound 6¼ ounce uninjured premature female infant in fair condition. The missile did not pierce the placenta and the placenta was removed manually. The uterine wall was then closed in two layers with continuous chromic #1 catgut sutures. The vesico uterine peritoneum was closed with a continuous 000 atraumatic chromic catgut suture. The uterine wounds were then debrided and a wedge resection performed requiring the excision of 3 to 4 cm. of myometrium in order to dissect out the entire missile tract. This was then closed with

interrupted figure-of-eight sutures. The abdominal viscera including the stomach, liver, spleen, small and large intestines were then carefully examined but no further damage was found. The bullet was found lodged in the abdominal wall in the right upper quadrant and was excised. With hemostasis being adequate, the abdomen was then closed. The infant expired 11½ hours after birth.

Immediately post operatively, the Levine tube was connected to a Wangensteen's suction. The patient was started on procaine penicillin 600,000 units twice daily and tested for sensitivity to tetanus antitoxin. The skin test was positive and the order for tetanus antitoxin was cancelled. The patient spiked a temperature of 102° on the third post-operative day but her post-operative course was otherwise benign and she was discharged on her sixth day. However, four days later she experienced the acute onset of left flank pain. She was seen in the hospital's emergency room where a physical examination was essentially normal except for fine basilar rales of the left lung. Blood pressure was 110/70, pulse 80 and temperature 98.8°. Urinalysis was negative and blood work showed a WBC of 14,200 with segs 82 per cent and lymphs 18 per cent. The hemoglobin was 12.0 gms. X-ray films of the chest and abdomen were obtained. The flat plate of the abdomen was reported as negative. The chest film revealed some haziness in the left costophrenic angle with some haziness above the left leaf of the diaphragm. This was interpreted by a radiologist as being a possible pulmonary infarction or changes secondary to left subdiaphragmatic inflammatory change.

The patient was re-admitted to the hospital and chest films six days later were reported as showing left subdiaphragmatic disease with extension into the left lower side of the chest. However, clinically the patient never developed any signs or symptoms consistent with a diagnostic of subphrenic abscess and she was felt to have had a resolved pneumonitis probably secondary to atelectasis. She did quite well and was discharged on her sixth hospital day.

Comment

Gunshot wounds of the pregnant uterus offer no real diagnostic problems. Preoperative evaluation and preparation should include the insertion of an indwelling gastric tube and a urinary catheter, with attention as to whether the stomach or bladder contains blood. If the patient's condition permits, roentgenograms should be taken routinely in order to demonstrate any unexpected positions of missiles or multiple foreign bodies.

Apparently the gravid uterus offers some kind of protection, as the general mortality in gunshot wounds of the abdomen without pregnancy appears to be greater. There have been only 3 maternal deaths reported in gunshot wounds of the pregnant uterus, two of which were due to peritonitis and the third was attributed to hemorrhage. This gives a mortality rate of 7.3% with no deaths occurring since 1912. On the other hand. McComb *et al*[7] recently reported a mortality rate of 21.9% in gunshot wounds of the abdomen and Bost[1] states that the general mortality ranges from 30 - 70% or even higher. The mortality rate of course is directly proportional to the number of organs injured, the time lag before surgery also being an influencing factor. From World War II statistics, Beebe and DeBakey[6] calculated an increase in mortality of approximately 0.5% for every hour's delay before operation.

There is no standard manner of treating these cases. However, in the proper management of such cases, one must consider several factors such as the condition of the mother, condition of the fetus and the extent of uterine injury. Laparotomy should always be done but the difficult question usually is whether to empty the uterus by cesarean section or to suture the wound or wounds in the uterus, repair the other damaged areas and await the delivery of the fetus vaginally. This was the situation in our case. Bost[1] stated that the general opinion would seem to be that the uterus should be emptied by cesarean section at the time of exploration, at almost any stage of pregnancy. We must make an exception to this statement for it would seem that where the fetus is previable or dead it would be best to avoid the performance of a cesarean section as the delivery of a living infant is its primary purpose. This would also obviate the necessity for cesarean sections with future pregnancies. If the fetus is viable and alive, immediate abdominal delivery probably offers the best chance of salvage. If conservative management is chosen, there is always the possibility that a previable pregnancy will proceed to viability. However, the possibility of placental injury, as in this case, or injury to the fetus must be considered as an argument against this method of management. If the condition of the mother is such that further surgery may endanger her

life, then conservative management with closure of the uterine wound or wounds and repair of the other damaged areas without cesarean section is advisable.

Cesarean hysterectomy or hysterectomy was performed in 4 reported cases but the only absolute indication for this appears to be uncontrollable hemorrhage. We do not feel it is necessary to give gas gangrene prophylaxis if the wounds are debrided adequately and early, for this infection develops only in necrotic tissue and usually within 24 hours. Postoperative complications in gunshot wounds of the abdomen are frequently of an infectious nature but apparently infection is not a significant factor in the treatment of such cases as this, for no case of puerperal sepsis has as yet been reported.

Summary

1. A case of a gunshot wound of the gravid uterus is presented.
2. The mortality rate in such cases has been 7.3% with only 3 maternal deaths reported. Laparotomy should always be performed and with a viable and living fetus, immediate abdominal delivery probably offers the best chance of salvage. However, in the proper management of such cases several factors must be considered, such as the condition of the mother, the condition of the fetus, and the extent of the injury to the uterus. The only absolute indication for cesarean hysterectomy appears to be uncontrollable. Infection is not a significant factor in the treatment of these cases.

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From Francois Mauriceau—Traite des Maladies des Femmes Grosses 1740.

PROBLEMS IN GALLBLADDER DISEASES

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The author considers the differences of opinion concerning the management of various gallbladder problems. These include particularly the handling of gallstones and acute cholecystitis. He concludes that patients should be made aware of silent gallstones, with early surgery in view, and that prompt operation should be done for cholecystitis.

The dilemma which confronts the young surgeon today regarding the treatment of gallbladder problems is nothing short of astounding. Why should this situation prevail? Why is there so much disagreement regarding the therapy of the various gallbladder problems? This dilemma is not unique with the gallbladder. On the contrary, it prevails rather generally in the surgical treatment of whatever organ, or organ systems, one might choose. It indicates, I rather think, that there is no one method of treatment which is vastly superior to any other. The method one chooses in the treatment of any one particular gallbladder problem is related to his training, intelligence, powers of logical reasoning, and technical ability. I feel sure that the surgeons' technical ability plays a greater part in the choosing of a surgical procedure than he oftentimes would care to admit.

Silent Gallstones

One of the really tough problems about which to properly advise a patient is the matter of the "silent gallstone." Should an individual with gallbladder calculi, in whom symptoms are absent, be subjected to cholecystectomy? An individual, for example, who has a normally functioning gallbladder containing, let us say, one large cholesterol stone? There is pretty general agreement among surgeons and internists that surgery is best for symptomatic stones and, therefore, no particular problem. The silent stone, however, produces three major types of reactions: (1) leave alone, (2) always operate, and (3) watch carefully and wait for symptoms.

The "leave alone" group would appear to be strictly in the minority. George Crile, in a personal communication to Dr. Jacob Riese[10] in 1951, states he would leave his alone if he had one. Dr. George Pack, on the other hand, in a personal communication to Dr. Riese,[10] said that he would prefer to have asymptomatic stones removed since the incidence of carcinoma is greater than the mortality for surgery. Almost every carcinoma of the gallbladder has had stones associated with it. In a questionnaire sent by Dr. Riese in 1951 to 40 prominent surgeons and internists over two-thirds were in favor of surgery.

Warren Cole[4] said, "Anyone under 45 years of age, with average life expectancy, should have silent stones removed by cholecystectomy because of the possibility of further complications." One must also consider the possibility that the present silent gallstone may mask or act as a "red herring" in diagnosing other disease entities in the upper part of the abdomen.

The frequency of the silent gallstone in the general population is not clear. Robertson,[11] in reviewing 1027 cases in which necropsy was performed and in which gallstones were found, discovered that in 61% of cases there had been no suspicion by the patient or attending physician that gallstones did exist. Probably on closer probing by doctors this figure would be reduced. Even so, it might indicate that silent stones are rather common. Cain and Donato,[3] in reviewing the incidence of gallstones in 6107 necropsies at the Medical College of South

Carolina and the Roper Hospital over the years 1913 to 1948, found an incidence of 36.3% of white females with stones in the 80 to 90 age group which, once again, might indicate a greater prevalence of silent stones than one ordinarily thinks.

Comfort,[6] in a review of a large series of cases with gallstones who came to operation for other problems, concludes that the patient with silent gallstones may be told he has about an even chance that symptoms will develop, one chance out of five that painful seizures will develop, and a small chance that jaundice will develop within 10 to 20 years. In addition, he should be told that the risk of surgical interventation is about 0.5% before complications and it goes up to possibly 3% if operation is deferred until complications or physical disability appear. Dr. Lester R. Whitaker[14] has written a very excellent and witty piece on the problem called, "The Gallstone: Silent, Growling, or Screeching." He also refers to the fact that practically all carcinomas of the gallbladder are accompanied by stones. James R. Marshall[7] pointed out in a paper read to the Southern California Chapter of The American College of Surgeons that there is no such thing as a silent gallstone. The mere presence of the stone would indicate an abnormal situation. Sir William Osler said, some 60 years ago, that there is no medical treatment for gallstones.

James R. Marshall[7] pointed out that in 1954 some 15,000 people died of gallstones and their related complications. There are some who feel that removal of a gallbladder containing silent stones is a purely prophylactic situation to be compared with the removal of breasts in women over 35 to 40 years of age whether masses are palpable or not. I cannot feel that these two situations are analogous primarily because a gallstone, even though silent, is not normal and, therefore, I do not place its removal in a prophylactic category. If one considers cholecystectomy for silent gallstones a prophylactic procedure then, possibly, watchful waiting might be in order. Some of those who feel that immediate operation is taboo also feel that the patient might have a hand in deciding whether to be operated upon. This would seem to me to be a rather ludicrous position. How can a patient decide intelligently when the doctor cannot? One should probably consider a statement made by Robertson[11] in a paper published in *Gastro-enterology* when he said, "Logically, if it is necessary to remove all gallstones, quiescent or symptom-producing, it is also necessary to test the gallbladders of all adults, both by cholecystography and by searching clinical examination, and if gallstones are found to suggest immediate operative interference." This is an extremely interesting observation.

Discussion

Where then to stand on this issue? I feel the patient should be made aware of the problem so that he understands that he has about an even chance that symptoms will subsequently develop. He should be told that there is a lessened, but significant, risk if surgery is done before complications develop or old age or physical disabilities occur; that the increase in risk is counter-balanced by the fact that if he defers surgery he may never require it.

If the patient strikes me as being one who might take the attitude he hasn't felt well since "that operation" I lean toward postponing surgery and watchful observation of the patient. If the patient is a sensible, mature, intelligent individual who understands the problem and will cooperate, then one is probably justified in watchful waiting. If symptoms appear, a firm stand is taken in behalf of operation.

Acute Cholecystitis

It would seem that, regarding the condition of acute cholecystitis, there should be rather general agreement as to therapy. One could hardly have a more erroneous impression.

The etiology of acute cholecystitis has certainly become more clear cut. Warren Cole[4] has pointed out that the belief that acute cholecystitis starts out as a chemical lesion is becoming more and more prevalent. He is convinced of this and believes further that infection, if present, is superimposed on the chemical cholecystitis. With rather general agreement regarding etiology, and with a considerable knowledge of the pathology, why should there be so many therapeutic camps? The main divisions regarding therapy are: (a) early operation, (b) late operation, (c) no operation and, (d) immediate drainage with late removal.

Early operation has many advocates.[1, 2, 9, 12] Why shouldn't it have? Is this not the logical approach? The fault I find here is in the time limit suggested by "early." I think that McEachern hit the matter squarely on the head when he stated that his group defines "early surgery" as the surgery performed as soon as the diagnosis is established and when the patient has been so prepared as to be in optimum condition for operation regardless of the interval between onset of disease and the performance of surgery.[12] I embrace this statement wholeheartedly and would only add that the least surgery performed should be cholecystectomy.

There are, of course, times when it might be technically impossible to perform cholecystectomy and in this instance an occasional cholecystostomy might be tolerated. There are also times during the procedure when the patients' condition becomes such that the operation must be terminated rather quickly and, under these circumstances, again cholecystostomy might be indicated. It might be argued that, if it is necessary to terminate the procedure rapidly because of the patients' condition, he should not have been operated upon in the first place. The point is, really, that cholecystectomy and cholecystostomy both subject the patient to a certain amount of stress. The stress need not be any greater as a result of a properly performed cholecystectomy. Consider how the morbidity is reduced when this acutely inflamed, often partially necrotic, occasionally gangrenous, pus filled sac, with or without perforation, is removed adequately. These patients may usually be discharged in a week to ten days following surgery. This includes the occasional patient who required exploration of the common duct.

The mortality rate is, I suppose, the main deterrent to operation for acute cholecystitis. Here again, however, the figures presented by various writers are at such a variance and so confusing that they should probably be ignored by the competent operator who has properly prepared his patient preoperatively. Mortality figures can be found in the medical literature for early, late, and no operation in any age group. These figures may run all the way from 0% to 25%. Some claim that the high mortality rate is primarily due to the age of the patient while others feel that the operation delayed after four days of illness is primarily responsible. One would do well to take with a grain of salt these various figures and heed Drs. Briggs, Beal, and Stevens[1] who, after reviewing the clinical course of 141 patients with acute cholecystitis who were operated upon as soon as the patients were in optimum condition without relation to the time of their disease, concluded that they had no desire to change their plan of therapy. It is extremely interesting to me that cholecystostomy was performed in only 8 of 144 cases and cholecystectomy in the rest with a mortality rate of 3.5%.

Conservative treatment is certainly no better than the above. Consider the figures of McCubbrey and Thieme[8] who report on the conservative therapy of 345 patients with acute cholecystitis. Of this group the disease was controlled in 280 (81.5%) patients, leading to elective surgery in 125 and discharge, without operation, of 154 patients. There was one death. There were 65 patients who required surgery — not of election — with a cholecystostomy rate of 40% and with 8 fatalities. The author labels these 65 cases as the price of conservative treatment. It is claimed that the mortality rate here was due to the age of the patient rather than conservative treatment. This is no doubt a factor in his mortality figure, but would not adrenal collapse be even more of a factor? How long can one be subjected to stress before reaching the stage of "exhaustion"? Would these eight deaths have occurred if operation had not been delayed until the last moment when it must have become an absolute necessity? Is this then an acceptable situation as the author suggests? I think not. The authors' figures simply enhance my attitude of proper operation at an optimum time. It is noteworthy also that no figures are presented for morbidity in these patients treated conservatively. Morbidity is a prime argument in favor of operative therapy. One might conclude from the authors' presentation that properly performed surgery at the optimum time is, actually, the conservative treatment.

Doubilet, Reed, and Mulholland[6] feel that definitive treatment for acute cholecystitis is

operation, but operation done during a quiescence stage of the disease. Figures are presented to show how appalling early operation is and these from institutions where highly trained surgeons operate under the best of modern conditions. The lesson here, I suppose, is that the non-institutional surgeon had better take heed and treat this condition non-operatively. Surely it must be agreed that, if the surgeon is technically capable, an acutely inflamed gallbladder is best removed.

Consider the results of a recent paper by Welch[10] wherein 100 consecutive cases of acute cholecystitis were operated upon with one cholecystostomy and 99 cholecystectomies done. There were no deaths. He emphasizes what I feel to be one of the biggest factors in a successful outcome of any surgical procedure and this is technique. Certainly I do not feel technique to be more important than an adequate background in anatomy, pathology, and physiology. I only wish to point out that in recent years I have the impression that surgical technique has been de-emphasized in the training of the young surgeon. Most surgical residents of today would be embarrassed to admit that they practice knot-tying out of the operating room in order to improve their ability and agility. How devastating for the patient and embarrassing for the surgeon who knows what should be done but is technically unable to do it.

Summary

In summary then, a patient with silent gallstones should be made aware of his problem. Surgery prior to complications would certainly seem to be the treatment of choice. Finally, if the gallbladder is acutely inflamed it would seem reasonable to remove it as soon as the patient has been optimally prepared.

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Binocular disparity in tonometry in normal eyes. Jervey, J. W., Jr., M. D. (Greenville) Eye, Ear, Nose and Throat Monthly 41:45, Jan. 1962.

In a study of 3,500 normal eyes the author finds that there are measurable differences in the pressures of the right and left eyes in five per cent. He believes that these differences can be explained on the basis of differences in techniques of tonometry and the patient's unavoidable reactions to tonometry. He believes that the observed discrepancies in the right and left eye pressures are of no clinical importance in normal eyes.

J. W. Jervey, Jr.

CONSTITUTIONAL HEPATIC DYSFUNCTION (GILBERT'S DISEASE)

A CASE REPORT

E. WALTER MASTERS, M. D.
Columbia, South Carolina

Disturbance of liver function from an unknown cause ("constitutional") must be kept in mind in diagnostic consideration of any patient with jaundice. The author reports one such case in detail, and comments on its significance.

This case of hyperbilirubinemia is being reported for two reasons. First, it is important to keep this in mind, particularly in the presence of epidemics of infectious hepatitis, and second, this specific constitutional defect has recently been studied and it is interesting to point out some facts that have been found about it.

Case Report

This 20-year-old man was known to be essentially free from any illness. He had no complaints. Nine months previous to the onset of jaundice he had been examined thoroughly and found to be entirely normal and to have no icterus. About June, 1960, it was noted by some of his friends that he had yellow eyeballs. At that time he had no other symptoms. He came under my care at this time and, because there was some hepatitis in the community, it was thought that this patient probably had infectious hepatitis. His urine was a little dark and was positive for bilirubin. When examined at that time, his blood count was perfectly normal. His hemoglobin was 15 grams; red cell count was 4,500,000; white count was 6,300; 70 percent polymorphonuclears, 30 percent lymphocytes. Serum glutamic acid - oxalacetic acid - transaminase (SGOT) was 73; total serum bilirubin was 7.6, with an indirect reading of 6.7 and a direct of .9. It was thought that he probably had acute infectious hepatitis and he was so treated, with modified bed rest.

On July 11, 1960, his SGOT was 36. His urine was negative. Total bilirubin had gone down to 4.1, with a direct of .2 and an indirect of 3.9. He was then returned to activity, still having had no real symptoms. In November, 1960, it was noted that he had some evidence of increasing yellowness of the sclerae. At that time his SGOT was 5; total serum bilirubin was 6.9 with a direct of 1.9 and an indirect of 4.0. He was not treated at this time because it was felt that he probably had some constitutional defect and really did not have hepatitis. In January, 1961, his direct reading was .84, indirect was 5.8 and cephalin flocculation was 4+ in 24 hours.

On March 31, 1961, the patient was brought into the hospital for liver biopsy. At that time his total serum bilirubin was 5.7 with a direct of 1.2 and an indirect of 4.5. At that time his total serum protein was 6.9, with albumin 4.2 and globulin 2.7. Calcium was 11 mg./100 ml. and phosphorous was 3.3. Prothrombin time was 14 seconds with a control of 13 seconds. X-ray examination of the chest and gallbladder was negative. Sedimentation rate was 10, corrected.

A percutaneous liver biopsy was done by Dr. William Cantey on March 31, and at that time the liver tissue was found to be entirely normal and was so reported by the pathologist, Dr. E. DuBose Dent. It was thought at this time, as it has been felt for some time, that this boy must have a case of constitutional hepatic dysfunction.

This case has several interesting points. The patient's family is well known to me. He has two sisters and a mother living and there is absolutely no icterus in the family. His father died at age 40 of coronary thrombosis and had never had icterus to anyone's knowledge. It would be interesting to follow his two younger sisters and see if they develop icterus at any time. Another interesting point in this case is that he had a 4+ cephalin flocculation, which is usually not present in this condition. He also had a little bilirubin in his urine at one time. This is also not usually true.

It has been found by study that the icterus in this syndrome tends to fluctuate a great deal and is associated with fatigue and other situations. It is important in the presence of this syndrome to be certain that it is recognized and that people who have it are not con-

demned to a diagnosis of chronic hepatitis with inevitable liver failure.

The ultimate outlook for this illness is not too well known. However, many patients have been followed for a good long while and they have developed no chronic liver disease.

It would be interesting to know what attitude the insurance companies would take toward insuring this person and also what attitude the armed services would take on inducting an individual of this type.

In 1957, Arias and London[1] demonstrated that the formation of bilirubin glucuronide in human as well as in rat liver involves a transfer by enzyme and liver miscrosomes of glucuronic acid from uridine diphosphate glucuronic acid to bilirubin. Deficiency of the transferase activity of liver microsomes in patients with constitutional hepatic dysfunction accounts for the difficulty in excretion of bilirubin in this case and in the cases that were followed by these people. The people studied in this case had rather high serum bilirubins—one being 8.8 and one 18.8. It was pointed out in a recent article by Foulk and Schoenfeld[2] that in individuals whose serum bilirubin is below 5 mg./100 ml. the defects of glucuronide conjugation have not generally been demonstrable by available methods. Some of these cases may represent a less severe genetic defect of hepatic glucuroneal transferase activity. Insensitivity of available methods may be responsible for failure to demonstrate a quantitative change in mild deficiency of glucuroneal transferase.

The salient features of these cases are as follows:

1. Mild icterus, usually asymptomatic, may be familial.
2. The major portion of the bilirubin is in the indirect fraction and there is no anemia.
3. The gall bladder functions normally. Usual liver function tests are normal.
4. The liver biopsy is entirely normal or occasionally shows a few fat cells infiltrating the liver cells.

Comments

A case of constitutional hepatic dysfunction has been described. It has been reported primarily to emphasize the importance of keeping this syndrome in mind, particularly in the presence of epidemics of hepatitis, as we have at present. The mechanism of this defect, which is presumed to be inborn and which is presumed to be as above, has been discussed.

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Effect of bacteria on vascular prostheses. R. R. Bradham, F. Cordle, F. A. McIver, (Charleston) Ann Surg 154:187, 1961.

This study was done in order to determine the effects of bacteremia on vascular prostheses. Teflon grafts were used to replace a segment of the abdominal aorta of ten mongrel dogs and were allowed to heal for at least 30 days. At varying intervals following the healing phase, a satisfactory bacteremia was produced in each dog by inoculating with a fresh, suspended culture of virulent Staphylococcus aureus organisms. Blood cultures were subsequently taken to verify the production of bacteremia and its duration. The dogs were sacrificed after the blood culture became negative. The grafts were then examined by culture and by microscopic section. Results indicated that the grafted segment was susceptible to circulating organisms and that these organisms were in part responsible for thrombus formation in several of these grafts. It was our conclusion that persons having vascular prostheses should be treated with antibiotics, following blood culture, during the course of any illness associated with the probability of an existing bacteremia.

R. R. Bradham

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Left Intraventricular Block

DALE GROOM, M. D.
Department of Medicine

Case Record—This electrocardiogram is similar to several recorded over a four year period on a 62 year old gentleman with angina pectoris. His angina was classical for coronary insufficiency: substernal pain radiating down both arms, coming on with exertion and promptly relieved by rest or nitroglycerin. Because of some associated dyspnea and orthopnea he had been carried on daily digitalis. There was no clear history of a myocardial infarction in the past, however sequential tracings showed varying degrees of S-T segment displacement in the left precordial leads, consistent with ischemia.

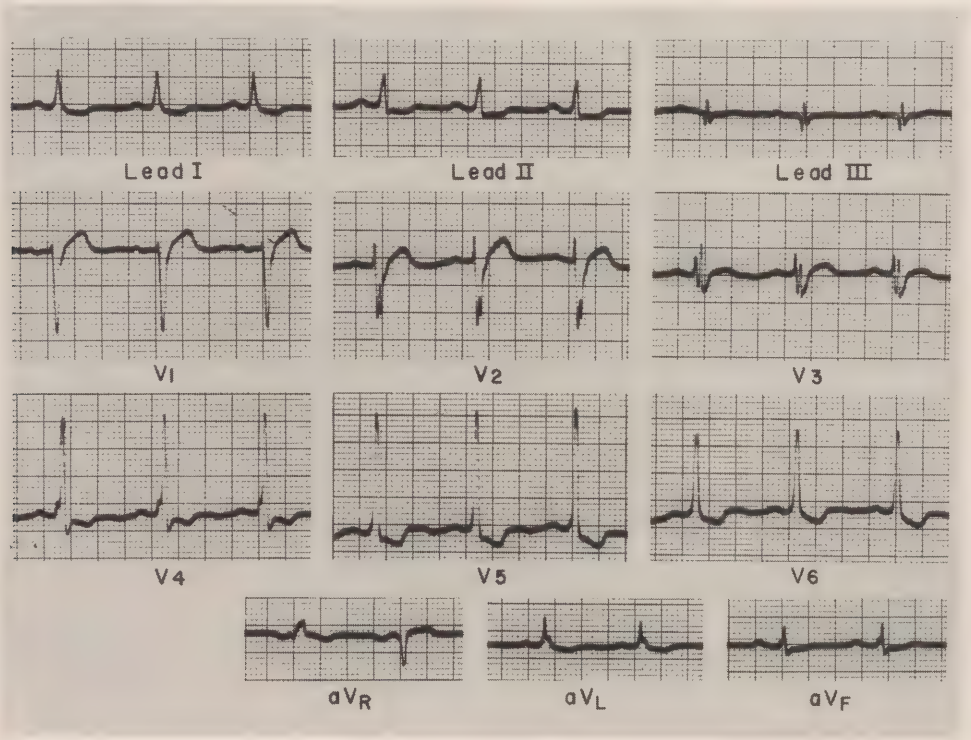
Additional problems in this patient were diabetes, claudication due to occlusive arterial disease in the right lower extremity and an abdominal aortic aneurysm. His heart was of normal size and contour roentgenographically.

Electrocardiogram—The rhythm is a regular sinus one at a rate of 80 with occasional ventricular ectopic beats (aVR) and a P-R interval slightly above the normal limit of 0.20 sec.

QRS complexes are variously slurred or notched in the different leads with a maximum width of approximately 0.10 sec. and small Q waves in lead III. Some delay in activation of part of the left ventricle is indicated in the delayed intrinsicoid deflections (about 0.06 sec) in V_4, and in the more than usual transition zone aberrations of the QRS of V_3 with its wide and slurred terminal portion following the RSR′ waves.

In the left precordial leads the T wave inversions are typical of those caused by digitalis. Also the minimal S-T segment depressions there could be accounted for on the same basis although at times, especially with a more rapid heart rate, these segment displacements would increase to 3 mm and more.

Discussion—Aside from the T wave changes and minimal delay in AV conduction (both attributable to the digitalis), this tracing is abnormal chiefly in the delay and probably in the pathway of conduction through the ventricles. The abnormality is quite localized—a focal block—and is evident principally in the



middle and left precordial leads, whereas the QRS complexes of the extremity leads are reasonably normal. Obviously it is not a bundle branch block for no delay in ventricular activation is seen either in V_1 or V_6 and the QRS is well under 0.12. There appears to be aberration both in the initial and the terminal phases of activation of only a portion of the left ventricular wall.

Conduction through the ventricles may be blocked at either the right or the left main bundles, or in their terminal branches, or in the myocardium itself as depolarization proceeds from the specialized conduction tissue through the ventricular wall generally in a direction from the endocardial to the epicardial surface. The right bundle courses along the right side of the interventricular septum to a point near the apex where it gives off branches which ramify extensively throughout all areas of the right ventricle. A somewhat different distribution obtains on the left: almost immediately after the left bundle crosses to the left side of the septum it divides into two groups of fibers, one called the anterior division which fans out superiorly and the other the posterior division which courses inferiorly and spreads out over the posterior and diaphragmatic areas of the left ventricle. A block in either of these two divisions would be circumvented by conduction over the other—often with little or no delay and hence little or no prolongation of the QRS complex. But the important consideration is that the route of activation of the left ventricle would be altered with resultant alteration in configuration of the QRS and, generally, the last depolarization potential to be recorded would be from the area overlying the block.

Quite a number of different ventricular conduction defects have been described in addition to the familiar right and left bundle branch blocks: "focal block", "pseudo block", "arborization block" and "peri-infarction block". Often the latter two terms are used synonymously in the literature. Criteria for diagnosis of peri-infarction block vary among different investigators but certainly that conduction defect is a fairly common accompaniment of coronary disease and it is an example of what is recently being designated as *left intraventricular block,* believed to be related to the architecture of the conduction system of the left ventricle.[1] Presumably these blocks arise from damage to the Purkinje fibers which conduct excitation radially across the ventricular wall because they appear simultaneously with or almost immediately after the other electrocardiographic signs of acute infarction, especially infarctions of the anterolateral wall. Occasionally the QRS may be prolonged to as much as 0.14 but it is usually within the normal range. There is as yet little evidence to prove the mechanism of peri-infarction block except the known vulnerability of the subendocardial layers which lie at the distal end of the coronary arterial circulation and the observed appearance of this left intraventricular block following infarction in patients with previously normal tracings.

Without an earlier normal ECG on this patient it is perhaps debatable whether his conduction abnormality is due to infarction, to ischemia and fibrosis from coronary insufficiency or to perhaps some congenital anomaly of conduction. Quinidine was not a factor. Most likely it is an acquired conduction defect produced by focal damage to the Purkinje fibers by his known coronary disease.

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DERMATOLOGICAL DON'Ts

Kathleen Riley, M. D.
Department of Dermatology

Pityriasis Rosea

White, Female, Age 25

HISTORY:

Two weeks previously patient noticed "ringworm" on right arm that did not respond to Desenex cream.

Two days previously patient noticed generalized asymptomatic eruption.

Patient was concerned because of the extent despite the fact she felt well.

PHYSICAL EXAMINATION:

Papulo-squamous eruption from the neck to the knees, small oval shaped lesions distributed in the lines of cleavage.

Centers of the lesions showed fine scaling.

Mucous membranes, palms and soles were clear.

DIAGNOSIS:
PITYRIASIS ROSEA

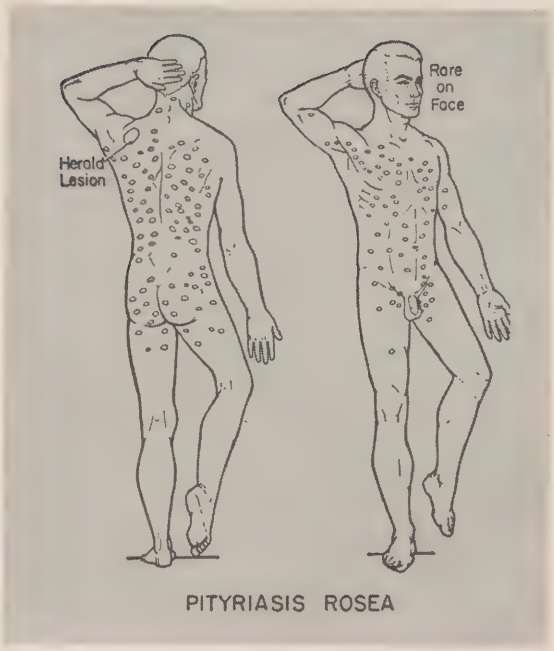
TREATMENT:

DON'T:

1. Forget to take blood to rule out secondary syphilis.
2. Forget to take a drug history to rule out drug eruption.
3. Use steroid systemically.
4. Make patient return for needless visits as there will be a spontaneous clearing within six to eight weeks.

DO:

1. Symptomatic treatment as simple antipruritic preparation—Quotane cream or lotion, Alpha Keri baths. Temaril systemically. Sun baths if possible.
2. Advise patient that this will not recur, immunization usually occurs.
3. Advise patient that this is not contagious.



What Are Your Ideas?

Your Association has launched a program to fight at the "grass roots" level within our state the latest effort to extend federal controls in the field of medical care—the King-Anderson Bill. (See page 104)

Such a program gathers momentum from its source—the individual South Carolina doctor. Your ideas and suggestions will be welcomed and studied carefully.

Read about the program and the listing of the materials available to you on page 104.

Then write your suggestions and ideas for further strengthening this program to Dr. Joseph I. Waring, Chairman, S. C. Medical Association Public Relations Committee, 82 Rutledge Avenue, Charleston, S. C.



President's Page

As the winter wanes, and spring begins to appear with summer not far away, many things begin to stir. Among these is the political pot, and as this pot begins to boil, many interesting things begin to unfold. One of the most informative results of people seeking office is the many things that can be brought to the forefront, concerning the welfare of the PEEPUL, and the many additional aids that can be promised during an election.

Since 1932, the Federal Government has assumed the benevolent role of assuming care of all people, both domestic and foreign, at the expense of the domestic. A good deal of the working time of the domestic people is now taken over by the Federal Government (all except the Labor Unions and they are smart enough to limit their working hours so that they make enough to live sumptuously and not overwork or over pay). Never did our forefathers dream of such taxes as we have now, and never did they ever dream of us ever being the ever-loving Uncle Sam that we have turned out to be to the world. The big stick has been forgotten, and it is only the blank check that is held in hand now, *with pen poised.*

For a great many of these years, especially since the years of the grab-all and hand-out, one of the principal professions to be whipped is the medical, for who is going to be happy if he has to spend all he makes on sickness. And even though sickness and health insurance have been available to the PEEPUL for some fifteen or more years, there are still those that think someone should take care of them through sickness, and many more are beginning to think that they should be taken care of even in health.

So, with this type of philosophy being promoted by the Ribicoffs and the Cohens, and the medical profession serving as the agitator, I think that it is time that we arouse ourselves, and begin to take a little more interest in politics. It is my considered opinion that we should begin to talk to the prospective candidates, ask some questions, and then pick and choose the ones that can come up with the best answers. This should not be as a society or an association, but as individuals. I long have advocated some such organization as a political action committee, not necessarily composed entirely of doctors, but of people who think like us and desire the same things that we do. If we could combine our efforts with others of the same likes and dislikes as we have, the accomplishments would be beyond our fondest dream. Now is the time to plan, to register, to ask questions, and to begin to work for those things that we think that candidates should be FOR and AGAINST.

The AMA has at last organized a POLITICAL ACTION COMMITTEE, which you are urged to join. This COMMITTEE is NOT incorporated purposely, and can therefore, participate in electing and supporting candidates political activity. We certainly can participate as individuals, or as a member of the AMPAC (American Medical Political Action Committee).

LET'S LET IT BE KNOWN NOW THAT WE ARE LOOKING FOR GOOD CANDIDATES, AND THAT IF FOUND, WE WILL WORK AND SUPPORT THEM.

Charles N. Wyatt

Dr. Wyatt Speaks Out Against the King-Anderson Bill.

(Get a recording of his talk for radio broadcast in your community, See Page 104)

Editorials

New Medical College President

Elsewhere in this Journal is a detailed account of the *curriculum vitae* of the well chosen new president of the Medical College of South Carolina, whom we welcome to his high position and congratulate on his achievement.

For some time since the elevation of the former president to the Chancellorship, the College has been under the guidance of an acting president, whose position by force of circumstances has been a difficult one. We believe he has served well in carrying on the work of the president, circumscribed as he was by the uncertainty of tenure and a similar uncertainty of permanence in the minds of his faculty.

The action of the Trustees is the result of long deliberation and careful consideration. The new president is well-known in the fields of research in pathology and is esteemed by the students to be their very best instructor. It may be expected that he will be in excellent position to provide a proper balance between these two fields of activity and to ensure that the Medical College maintains that position for which it was intended of a first class teaching institution.

English Medicine

Remarkably little has been published in this country regarding results of socialized medicine in England from the viewpoint of the English people themselves. The letter below is an interesting commentary on the British Health Service. It was written to me by a patient who is an Englishman of considerable distinction, he having served two terms as a Member of the British Parliament before coming to the United States to build a successful business. Now a resident of Charleston for several years, surely he can qualify as one who has witnessed firsthand the contrasting systems of medical practice in the two countries.

Enclosed with his letter was a page from the London Sunday Times depicting dreary wards and long outmoded construction of major hospitals of the metropolis. These scenes are familiar to those of us who have had occasion to visit hospitals in London and see their hopelessly overcrowded patient and laboratory facilities.

December 9th, 1961

"Dear Dr. Groom,

I am enclosing with this letter a section of the Sunday *Times*, England. This has been sent to me by my daughter and has only arrived this week.

The awful position of English Hospitals will be interesting to you to show what it means to be owned by the Government. The total cash available to keep these hospitals up to date is so very small for the next ten years, so there will be almost no progress during that time.

Government ownership dries up the wells of Charity, makes Municipalities indifferent and leaves everything to the whims of politicians and bureaucrats. It places the people so far away from the individual control of Hospitals.

Another thing this article shows up is that in the Reign of Queen Victoria there were 1,800 hospitals built, and since she died there have been hardly any constructed. So the people of England, my ex-countrymen, must surely be tough people to survive their medical surroundings. I agree with you in this estimation of the stamina of the English people.

You will notice there is also similar trouble in London. There are over 4,000,000 homes built prior to 1890 and there is such a shortage that some people have to live in trucks (*Times*) and there seems to be no hope of getting houses built to give families a front door of their own. It is impossible to get private enterprise moving owing to the mountains of red tape expressly devised to prevent the building of homes by private enterprise. The people who do it now are local authorities and the Central Government. So I hope we will not drift this way here in the U. S.

(signed) Harry Becker"

While it is true that these conditions antedated the advent of the British Health Service, and doubtless are due in some degree to economic and other factors quite apart from the socialization of medicine, one wonders how much England's swing to the left has contributed to the overcrowding of these ancient facilities by the quest for free medical care and how much the frustration of free enterprise—both in business and in medicine—has and will continue to hold back the progress of medicine in England.

Dale Groom, M. D.

Think or Drink

"Afternoon activities will feature a vascular symposium," says an AAGP program announcement. Sounds very appropriate to have a lot of vessels handy at a symposium (Greek —a drinking party).



"DEAR, WHAT WAS YOUR MOTHER'S REMEDY FOR A COLD AGAIN?"

South Carolina Medical Association

Program for Annual Meeting
9-10 May 1962

The program for the annual meeting in May has now been arranged and all guest participants have accepted their invitations. On the afternoon of 9 May 1962 the following topics will be presented:

Arthritis from the Clinical Viewpoint
Tetanus
Pulmonary Complications in Surgical Patients
Accident Prevention

On 10 May 1962 the following topics will be presented:

Hypercalcemia
Laboratory Aids in Hematologic Problems
Respiratory Embarrassment
Luncheon Panels (See below)
Medical Emergencies
Clinico-Pathological Conference

The program will be short and to the point. We hope that attendance will be good. The luncheon panels referred to above are an innovation which we hope that members of the Association will enjoy. There will be eight groups headed by out-of-state speakers and supported by a member of the faculty of the Medical College of South Carolina and at least one practitioner. Places at each table will be reserved for twenty members. Although topics will be assigned to each panel, it is to be hoped that informal discussion and friendly conversation will also occupy suitable proportions of the agenda. For those registered at the Ocean Forest Hotel, this luncheon is included in the American plan. For those not staying at the hotel an appropriate charge for the meal will be levied.

News



Dr. H. Rawling Pratt-Thomas, newly elected president of the Medical College of South Carolina.

Dr. Pratt-Thomas Named President Of Medical College

Dr. H. Rawling Pratt-Thomas was chosen president of the Medical College of South Carolina at a meeting of the institution's board of trustees February 4.

Dr. Pratt-Thomas, 48, succeds Dr. John T. Cuttino, who has been acting president since the retirement of Dr. Kenneth Lynch two years ago. Dr. Cuttino will head the Department of Pathology.

Dr. Thomas A. Pitts of Columbia, chairman of the board, said Dr. Cheves Smythe, associate professor of medicine, was tentatively named to succeed Dr. Pratt-Thomas as dean of the college's School of Medicine. Dr. Pitts said some "financial arrangements" relative to Dr. Smythe's appointment were subject to the approval of the Budget anl Control Board.

Dr. Pratt-Thomas said from 10 to 15 additions to the present staff at the college would have to be made and many key places had to be filled, but it will be some time before the details are worked out."

The 48-year-old college president joined the college's Pathology Department in 1941. He is now chairman of the department and consultant in pathology at the Charleston Naval Hospital.

He has been particularly active in research work dealing with problems related to cancer of the lung and the uterus.

Under the auspices of the Tobacco Industry Research Committee, Dr. Pratt-Thomas was one of the original group of 12 pathologists from throughout the United States making a coordinated study of environmental factors concerned in cancer of the lung.

He received the award of the South Carolina Division of the American Cancer Society in 1955 for his contributions to the control of cancer.

In 1958, he receivel an award from the members of the Student American Medical Association as the best instructor at the Medical College.

He has been active in the development of the cytologic screening programs throughout the state. He is at present director of the School of Cytotechnology—the study of cells—at the medical college.

Dr. Pratt-Thomas said his new position will leave him no time for private practice.

H. Rawling Pratt-Thomas, M. D.

Dr. Pratt-Thomas was born in Barnsley, England, in 1913. He was reared in Sumter County, South Carolina, and received his A. B. degree from Davidson College in 1934 and his M. D. degree from the Medical College of South Carolina in 1938. He received his internship and residency training at the Cincinnati General Hospital. He is a member of the American Medical Association, College of American Pathologists, and American Association of Pathologists and Bacteriologists. He is a former chairman of the Section of Pathology of the Southern Medical Association. He is past president of the Charleston County Medical Society and the South Carolina Society of Pathologists. He is a Diplomate of the American Board of Pathology and is the consultant in pathology at the Charleston Naval Hospital. He has written some 35 scientific articles and is a member of the National Honorary Scholastic Medical Society, Alpha Omega Alpha. Dr. Pratt-Thomas was Chairman of the Department of Pathology and was formerly Dean of the School of Medicine.



Dr. Pratt-Thomas confers with Dr. Cheves McC. Smythe, his successor as dean of the School of Medicine.

Dr. Cheves McCord Smythe

Dr. Smythe was born in Charleston, May 25, 1924. He attended Taft School and Yale College, 1942 to 43. He was graduated from Harvard Medical School, *cum laude*, 1947 and then became intern and assistant resident, Boston City Hospital, later resident, Chest Service, Bellevue Hospital. He was a fellow at Presbyterian Hospital, New York, 1950-52.

He served as Lieutenant, (Medical Corps) U. S. N. R., Camp Lejeune, N. C. and later became chief resident, Harvard Services, Boston City Hospital. He has been a John and Mary R. Markle Scholar in Medicine, 1955-60. In turn he has served as instructor, associate, assistant professor, and associate professor (since 1960) of medicine in the Medical College of South Carolina.

He is certified by the American Board of Internal Medicine. He is a member of many medical societies, including the American Federation for Clinical Research (Council Member, Southern Section), Southern Society for Clinical Research, Society for Experimental Biology and Medicine, American College of Physicians (Associate).

Oconee Doctors Elect

Dr. R. K. Nimmons of Seneca has been elected president of the Oconee County Medical Society.

Named to serve with him are Dr. D. O. Royal of Westminster, vice president, and Dr. E. M. Davis of Walhalla, secretary-treasurer.

Dr. Nimmons will be a delegate to the state society meeting, Dr. J. H. Bowers was named censor.

The staff of Oconee Memorial Hospital recently selected Dr. H. W. Wells as chief.

Other new officers are Dr. William Gillmore, secretary; Dr. J. H. Bowers, chief of medicine; Dr. H. B. Mays, chief of surgery, and Dr. F. B. Adams, chief of obstetrics.

Dr. L. E. Mays of Seneca was named hospital trustee. The surgical committee is composed of Dr. H. B. Mays, Dr. Nimmons and Dr. S. B. Moyle of Walhalla.

Frederick Heads York County Medical Society

Lawrence D. Frederick has been elected president of the York County Medical Society. Elected to serve with him were Dr. George Adickes, vice president, and Dr. Roderick Macdonald re-elected as secretary and treasurer.

Hanna Heads Medical Group

Dr. Charles Hanna, who has served as the Chief of Staff at Spartanburg General Hospital has become president of the Spartanburg County Medical Association.

Other officers to take office were Dr. Clarence Lyles, president-elect for 1962; Dr. Michael Patton, vice president; Dr. Frank Weir, Jr., secretary; Dr. Paul Cook, treasurer. Dr. Fred Adams is the Delegate to the South Carolina Medical Association.

Three Physicians Join State Hospital Staff

Three additional physicians have assumed their positions on the medical staff of the South Carolina State Hospital, as announced by Dr. William S. Hall, hospital superintendent.

Dr. Sedgwick Simons and Dr. Erico M. da Silva have been assigned to the Medical-Surgical Service, The James F. Byrnes Clinical Center; and Dr. Marion B. Kennedy, Jr., is on the Admission-Exit Service, Columbia Unit.

Originally from Charleston, Dr. Sedgwick Simons secured his Medical Degree in 1926 from the Medical College of South Carolina. Following graduation, Dr. Simons was Assistant to the Professor, Department of Clinical Pathology, Medical College of S. C., for about three years.

He was afterward associated with the South Carolina State Board of Health in the capacities of County Health Officer; District Health Officer and then Director, Division of Venereal Disease Control. After many years in this field, Dr. Simons entered the area of general medicine as resident physician at the Berkeley County Hospital, Moncks Corner, where he remained until he became a member of the medical staff at the S. C. Sanatorium, State Park, resigning from there to join the S. C. State Hospital medical staff.

Dr. Erico M. da Silva of Cataguazes, Minas, Brazil, has been in the United States since 1951. A graduate of the local Brazilian schools, his pre-medical and

medical education were secured in the University Minas Geraes from which he received his Medical Degree in 1949.

A rotating internship was served at St. Mary's Hospital, Huntington, West Virginia, and a general surgical residency at St. John's Hospital, Lexington, Kentucky, prior to a residency in special surgery in the Millard Fillimore Hospital, Buffalo, New York.

From there he went to the Earl Campbell Clinic, Chattanooga, Tenn., as preceptor in general surgery, remaining until July 1957 when he returned to Brazil.

Returning to the United States in July 1958, Dr. da Silva for brief periods was a staff physician at the Lynchburg Training School, Colony, Va., and at the Florida State Hospital, Chattahoochee, Florida, prior to being on the staff of the Huntington State Hospital, Huntington, West Virginia, coming from there to the South Carolina State Hospital.

Dr. Marion B. Kennedy, Jr., a native of Orangeburg, S. C., graduated from the Medical College of South Carolina in 1960. He has just completed a one year internship at the Columbia Hospital, Columbia.

In addition to his duties as a staff physician on the Admission-Exit Service, Columbia Unit, Dr. Kennedy is participating in the psychiatric residency training program.

He is a member of the U. S. Army Reserve.

VA Hospital Promotes Dr. Louis Birch

Dr. Louis Birch has recently been promoted to the position of Chief of the Medical Service at the VA hospital in Columbia.

Dr. Birch was born in Warsaw, Poland. He received his M. D. degree from the Medical College, School of Medicine, University of Pennsylvania, in 1932, and completed a two-year internship at the Jewish hospital in Philadelphia and year's residency at the W. C. Sanatorium, Liberty, N. Y.

He was engaged in private practice in Philadelphia from 1937 to 1939. He was certified as a diplomate by the American Board of Internal Medicine in 1956. Dr. Birch has had continuous service with the VA since December 1939 except for a year's active duty with the U. S. Army during World War II, and has served as assistant chief of the medical service at this hospital since 1949. Other government service includes active duty as reserve officer with the Civilian Conservation Corps from November 1934 to November 1935 and physician with the Department of the Interior, Bureau of Indian Affairs, at Belknap, Mon., from November 1936 to November 1937. He is a member of the American Medical Association and the South Carolina Heart Association.

Dr. Parker Again Heads Roper Board

Dr. Edward F. Parker has been re-elected unanimously to serve as chairman of the Roper Hospital Board of Commissioners.

Also re-elected was Dr. J. I. Waring, vice chairman. Dr. Henry C. Robertson was elected secretary.

Other board members are Dr. Bachman S. Smith, Jr., Dr. J. R. Sosnowski, Edward Kronsberg, Hugh C. Lane, Harold A. Petit and Frank S. Hay.

Dr. G. C. Dickson

Dr. Griggs C. Dickson of Hartsville has passed the American Board of Pediatrics.

Union Community Hospital Annual Clinic

The annual Medical and Surgical Clinic of Union Community Hospital was held January 29 and was preceded by a banquet January 28.

Ex-Spartanburg Doctor Retires

Dr. Edgar A. Hines, former chief resident physician at Spartanburg General Hospital, has retired from the staff of Mayo Clinic in Rochester, Minn.

Dr. Hines' retirement became effective Jan. 1 and he has moved to Brevard to make his home.

He will begin a series of lecture engagements early next month.

Dr. W. K. Wood Begins Medical Practice In York

Dr. W. K. Wood is in York to practice medicine in association with Dr. G. F. Hiott.

Wood, a graduate of the South Carolina Medical College, came to York from Hazard Memorial Hospital in Hazard, Ky. He is a native of Florence and a graduate of Clemson College.

'Medical' Views Given By Hollings

Gov. Ernest F. Hollings maintains that legislation "should be only the last resort" to make sure of proper medical practices.

Writing in the magazine *New Medical Materia,* Hollings says, "The real answer — the best answer — to the problem is self-discipline by the profession itself."

An article by Hollings in the January issue of the magazine is entitled "Don't Substitute Laws for Self-Discipline."

He said the best "antibiotic I know would be the self-discipline which Dr. Harold Jervey (Columbia physician) of my own state describes in his April *New Medical Materia* article."

He said if medicine fails to patrol its own borders, there will be other groups — "logically state legislatures" — who will have to take the responsibility.

He said legislators are not prepared to handle a medical discipline problem and lawmakers are reluctant to enter such a province.

Generally, he said, doctors have kept their houses in order, "otherwise, the public would be alarmed, and legislative halls would be ringing with cries for regulation."

Dr. Ennis To Open Office In Camden

At midnight on December 31, 1961, a naval medical career of over twenty years ended for Captain Henry R. Ennis (MC) United States Navy, when he retired from active duty.

HOW TO HELP KILL THE KING-ANDERSON BILL. SEE PAGE 104

Captain Ennis is a board certified orthopedic surgeon and a member of many medical societies including the American Academy of Orthopedic Surgeons.

While in service he held numerous positions including the Chief of Orthopedic Suregons at the Naval Hospital in Oakland, California, Pensacola, Florida and Charleston, S. C.

Dr. Ennis will open offices in Camden.

Woodruff Doctor To Practice At Spartanburg

Dr. John A. Workman, native of Woodruff, has completed two years of special training in anesthesiology at Duke Hospital in Durham.

He is the son of the late Dr. and Mrs. H. H. Workman of Woodruff and began practice in Spartanburg, February 1.

A graduate of Woodruff High School, Wofford College and the Medical College of South Carolina, he entered James Walker Hospital in Wilmington, N. C. in 1945.

Dr. Workman also had two years training in internal medicine at Veterans Hospital in Columbia. Prior to going to Duke he was associated with Dr. B. J. Workman, Sr. and Dr. B. J. Workman, Jr. at Workman Memorial Clinic.

Medical College Gets Research Grant

The Medical College of South Carolina has received a $82,538 research grant from the National Institutes of Health.

Dr. Luther L. Terry, surgeon general of the Public Health Service, told Sens. Olin D. Johnston and Strom Thurmond the grant is one of the first in the country approved under a program established by a 1960 law.

A hospital spokesman said the funds cannot be used for construction of research facilities but may be used for such things as salaries of research personnel, operation of facilities for animals used in research and for the exploration of ideas.

The spokesman said the funds probably will be used to aid research programs already in progress at the college.

The American College of Surgeons will hold its final 1962 sectional meeting in Washington, D. C., April 16 through 18. More than 1,500 doctors are expected to attend this meeting, open to all members of the medical profession. Headquarters hotel is the Sheraton-Park.

Selective Service

Selective Service throughout the country has been called upon to deliver 840 physicians for induction before the end of February, 1962. This call-up is not evenly distributed and cannot be as it is on an age basis. Physicians who are in training beyond the intern level are vulnerable unless they have completed their active military requirements or are proceeding under the Armed Services Residency (Berry) Program or under the Public Health Service Residency (Cord) Program.

Under the law, if they are not granted a further deferment, physicians are selected for induction in the following sequence:

a. Non-fathers who have not attained their 26th birthday;
b. Fathers below twenty-six years of age; and,
c. Without regard to parenthood, those physicians who have reached the 26th anniversary of the date of their birth. (Within this last group individuals are selected in sequence of dates of birth, the youngest going first.)

The induction calls currently in process are being filled with all physicians in Groups a and b, above, and those in Group c who were born after June 30, 1934; that is, those under 27½ years of age. Whether or not additonal calls for physicians are going to be levied depends upon the numbers which are needed by the Armed Forces, the number of those who are released from active duty and the number of physicians who enter active military service through other means. In this regard, at this time the Selective Service System is not examining physicians born prior to January 1, 1933, and *it is probable that induction calls during the next six months will be filled with physicians under 28 years of age.*

The Month In Washington

The American Medical Association again endorsed a legislative proposal that the federal government help finance construction of new medical schools and expansion and modernization of existing ones.

Dr. Gerald D. Dorman of New York City, a member of the A. M. A. Board of Trustees, told the House Interstate and Foreign Commerce Committee:

"We believe that there is need for assistance in the expansion, construction and remodeling of the physical facilities of medical schools, and, therefore, a one-time expenditure of federal funds on a matching basis is justified, where maximum freedom of the school from federal control is assured."

Dr. Dorman was presenting the A. M. A. position on the Kennedy Administration's 10-year, $932 million program (H. R. 4999) for federal aid to medical education. The legislation also proposed scholarships for medical and dental students.

"If the high standards of medical education are to be maintained, increased attention must be given to

the adequacy of physical facilities, the availability of qualified instructors and the availability of teaching material and patients for the clinical phases of medical education," Dr. Dorman said. "Any attempt to increase the number of medical students without regard to these conditions will result in a lowering of the standard of medical education. At this time, priority should be given to an increase in the physical facilities available for medical education."

Dr. Dorman said the A. M. A., had not taken a position on the other sections of H.R. 4999. However, he reviewed related A.M.A. programs.

"For some time, the American Medical Association has been aware of the decline in the number of eligible college students seeking admission to medical schools," he said. "This apparent shift away from medicine is due, in part, we believe, to the high cost in time and money of securing a medical education. This trend has been accentuated by a dramatic emphasis on careers in science and engineering. . .

"The House of Delegates of the American Medical Association in November, 1960, established two programs, the objectives of which are complementary and interrelated.

"First, the House authorized a student honors and scholarship program designed to focus attention on careers in medicine, to attract a substantial group of able students to prepare for admission to medical schools and to assist financially a limited number of outstanding students who, for financial reasons, are unable to pursue a career in medicine.

"Second, the A.M.A. House of Delegates has adopted a student loan program designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine."

Dr. Dorman also pointed out that the A.M.A. in the past 10 years, in collaboration with the Association of American Medical Colleges, had aided interested organizations in the establishment of six new medical schools." Currently, commitments have been obtained for another five schools and we are in consultation with sixteen institutions or organizations presently contemplating the establishment of new medical schools," he added.

* * *

The A.M.A. said it would be irresponsible to combine the King-Anderson bill with legislation that would permit physicians and other self-employed persons to defer federal income tax on income placed in specified private retirement funds.

Sen. Clinton P. Anderson (D., N. M.), co-author of the King-Anderson bill which would provide limited health care for aged persons under social security, suggested the combining tactic during a televised debate on the medical care issue with Sen. John Tower (R., Tex.).

The private retirement legislation—H.R. 10, the Keogh bill—would extend to an estimated 11 million self-employed and their employes the same tax benefits now provided to about 20 million wage earners covered by 66,000 company pension plans.

"This 'doubling-up' proposal of Sen. Anderson certainly proves the insincerity of the King-Anderson bill," Dr. F. J. L. Blasingame, Executive Vice President of the A.M.A., said. "It lays bare the fact that this is wholly a political issue and not a sincere attempt to grant meaningful medical care for the aged.

"It would be an irresponsible bit of legislative slight of hand to combine Sen. Anderson's proposed compulsory medical care program with a bill to eliminate tax inequities inflicted on the self-employed.

"Such unwarranted action could only serve Sen. Anderson's own political ambitions at the expense of millions of Americans.

"The bills have nothing in common. There is no reason whatsoever for combining them except that Sen. Anderson is attempting to harass critics of his bill into silence.

"He even calls the Keogh bill the 'doctors' special pension program, ignoring the fact that doctors make up only about 2.6 per cent of those self-employed who would be getting tax equity."

The Keogh bill has received widespread bi-partisan support in both houses of Congress. It was passed by an overwhelming vote in the House last summer and cleared the Senate Finance Committee by 13-3 vote.

DIET NOTES

Low sodium diet booklets, prepared by the American Heart Association, are available from the S. C. Heart Association, 1200 Henderson St., Columbia, to doctors, on request. They are as follows: 500 milligrams sodium, 1000 milligrams sodium, and mild sodium restriction. These are suitable for private patients and are good references for doctors and nurses, as well as dietitians. Sample copies of these may be obtained from me, on request.

Simple, two-page low sodium diets (500 mg. Na, 1000 mg. Na, and mild Na restriction) may be obtained from me, in moderate quantities, on request. I also have simple, one-page combination low sodium—low calorie diets, suitable for the overweight patient with hypertension.

Write to:—
Margaret Freeman, Dietitian
Medical College Clinic
Charleston 16, S. C.
Heart Disease Control, State Board of Health

FIGHT THE FIGHT THAT THREATENS YOU TODAY. See Page 104.

Dr. Rogers Moves

Dr. George C. Rogers of Spartanburg has moved his office to No. 7 Catawba St.

Colleton County Hospital Elects Officers

The medical staff of the Colleton County Hospital has elected Dr. W. E. Fender, chief of staff, Dr. A. C. vonLehe, assistant chief of staff and Dr. B. C. Phillips, secretary and treasurer. The new officers will serve for a two year term.

Nicholson and Beasley Associated

Dr. Frank W. Nicholson and Dr. Joseph O. Beasley announce their association for the practice of ophthalmology at 711 North Church Street, Spartanburg, S. C.

AAGP to Hold Scientific Assembly

The American Academy of General Practice will hold its Fourteenth Annual Scientific Assembly April 9-12 in Las Vegas, Nev. Those interested may write:

The American Academy of General Practice
Volker Boulevard at Brookside
Kansas City 12, Missouri

Roper Project Bid Accepted

A $3.8 million bid for construction at Roper Hospital has won the approval of the Medical Society of South Carolina.

The expansion will be financed entirely through funds of the Medical Society of South Carolina.

"No public funds will be used in the program," Dr. Ralph R. Coleman, president of the society, said today.



"Now I know why he saves his sleeping pill until visiting hour!"

The planned addition will increase Roper's bed capacity by 38 beds to 275. A $375,000 project earlier in the year, the Morawetz Building, had added 72 beds to make the present total of 237.

The latest addition will include a pharmacy, medical supply storeroom, physical therapy department, intensive care unit, private emergency facilities, X-ray department and snack bar.

Civil Defense

Training Program

The knowledge built into the Medical Self-Help Training program will be a major factor in reducing loss of life in the event of wide spread natural disaster or national emergency.

The MSH program is designed to instill in individuals and families a confidence in their ability to survive, along with the skills to make them self reliant until they can obtain a physician's services. This unprecedented program is keyed to prepare the American people to care for themselves, where necessary, by their own ingenuity and with the resources they may have on hand at the moment of disaster.

In South Carolina the MSH plan is a combined undertaking of the S. C. Civil Defense Agency, State Department of Health and the Civil Defense Adult Education division of the State Education Department. Coordinating the program for the three agencies are Dr. C. L. Guyton, assistant state health officer, Arthur A. Bushouse, Health Mobilization representative, S. C. Civil Defense Agency and Joel Kelly of the Education Department.

First objective of MSH is to instruct some 1,500 South Carolinians. To achieve this initial goal, members of the State Health Department will be employed. The first group of supervising nurses met in Columbia February 14-16 for three days of intensive instruction in all phases of the MSH program. These nurses will, upon returning to their respective counties, begin instructing additional personnel who will conduct the citizen classes.

Two years in development, the MSH program was created by the Public Health Service of the Department of Health, Education and Welfare in conjunction with the Office of Civil Defense and the American Medical Association's Council on National Security and Committee on Disaster Medical Care.

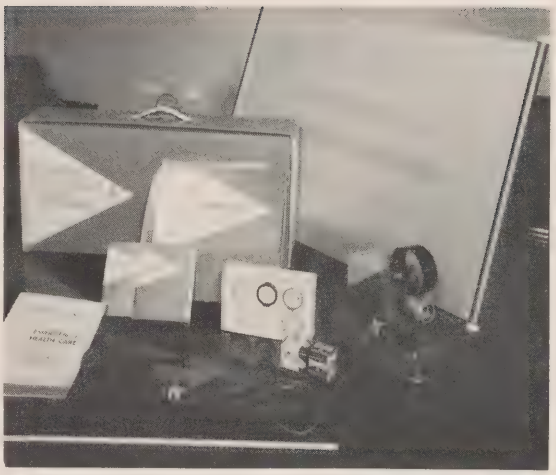
In referring to Medical Self Help Training the

AMA has said, "Members of the medical profession have an opportunity to make a significant contribution to strengthening our civil defense capabilities by supporting this program and offering all possible cooperation in its conduct." Thus, a key figure in the training program will be the practicing physician. He will be asked to advise and provide the professional leadership so necessary for the successful accomplishment of this nationwide effort.

Centered on the critical two-week period following a nuclear attack, the training will cover such subjects as radioactive fallout and shelters, hygiene, sanitation and vermin control, shock, bleeding and bandaging and even emergency childbirth.

The two major components of the MSH program are the "Family Guide—Emergency Health Care," and an ingenious training kit.

The "Family Guide" is a manual which contains instruction for survival and emergency health care. The kit contains all the aids, manuals, slide projector and screen needed to present the 16-hour course, usually presented in eight two-hour sessions.



Incorporating the latest developments in training aids, the Medical Self-Help Training kit (pictured above) is the result of two-years of research, testing and revision. The kit contains a new type of film strip projector, a daylight screen, twelve film strips, student handbooks and twelve instructor guides.

Correspondence

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

January 24, 1962

To The Editor:

Since 1957, infectious syphilis has been increasing at an alarming rate in all races, sexes, ages, social groups, and geographic areas. Physicians who have not observed a single case of infectious syphilis in 20 years suddenly are finding it among their patients.

Concurrent with this resurgence, unfortunately, is a paucity of venereal disease literature and information available to the private physician.

To partially alleviate this situation and serve a pressing need, the Venereal Disease Program of the Public Health Service routinely abstracts current articles on venereal diseases from almost 1,000 journals both domestic and foreign. A publication entitled "Current Literature on Venereal Disease" including these abstracts is printed three or four times a year and indexed annually. It is distributed regularly free of charge to physicians on their personal request.

Will you please, as a service to your readers, alert them to the availability of this publication and suggest that if they wish to receive it, they may write to Communicable Disease Center, Atlanta 22, Georgia, Attention: Dr. William J. Brown, Chief, Venereal Disease Branch, requesting that their names be added to the mailing key for "Current Literature on Venereal Disease."

Sincerely yours,
William J. Brown, M. D.
Chief, Venereal Disease Branch
Public Health Service

WIN THE BATTLE AGAINST THE KING-ANDERSON BILL. See Page 104.

Public Relations

Calling All South Carolina Doctors

In the Fight Against the King-Anderson Bill! Your Association, deeply concerned over the latest drive to socialize medicine — the King-Anderson Bill — offers South Carolina's physicians the means to combat this threat through a program of public information designed to influence the people of *your* community.

A hard-hitting "grass roots" program has been prepared by the Association's public relations counsel, Tobias & Company, of Charleston, under the supervision of your Association's Public Relations Committee.

Here you will find an outline of the program and the materials available to you to help in this crucial fight. Act now before it is too late.

Radio:

Newest phase in your public relations program. Public service time on local radio stations is available to all county medical societies. Radio is a powerful voice, reaching a broad audience. It offers you and members of your society an unparalleled opportunity to arouse community support to defeat the King-Anderson Bill. It gives your society an effective method of keeping the community informed on matters of local medical interest.

Prepared recordings are available for your immediate use (see order blank below). These recordings have been recorded and edited. All you need do is place the recordings in the hands of the managers of your local radio stations.

Subject matter:
Three recordings deal with the King-Anderson Bill.

#1 — Dr. Charles N. Wyatt, president of the state association, speaks out against the King-Anderson Bill.

#2 — Quotations from Congressman Bryan Dorn and a prominent South Carolina newspaper support the stand against King-Anderson.

#3 — An informal down-to-earth discussion of the King-Anderson Bill and what it can do to the taxpayer's pocketbook.

#4 — An expose of quackery. How to recognize a quack and how citizens in your neighborhood may protect themselves against these unscrupulous salesmen.

Local problems:
On request, scripts have been prepared dealing with specific community problems. This service is available to all county medical societies.

Speakers Bureaus:
Twenty-two county societies have speakers bureaus. These bureaus, when functioning actively, give physicians a splendid opportunity to meet face-to-face with their friends and neighbors. The majority of civic clubs are eager to know that there is an available source of speakers. Club presidents have already received letters informing them of this service. Basic news releases have also gone to newspapers in the areas where bureaus have been organized.

Materials Available to You:
Speeches:

#1—King-Anderson Bill versus Kerr-Mills Law

#2—Food Faddism

#3—The Rising Cost of Hospitalization

#4—Hidden Hazards (Household Poisons)

#5—The Care and Preservation of the American Businessman

#6—Mental Health

#7—Medicine as a Career

#8—Seven Ways to Cut Your Medical Expenses

Speakers Bureau Kit

Basic News Release (to be completed and sent to local newspapers at time of speaking engagement)

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8 of 10 Americans Oppose Higher Taxes for Health Care, New Opinion Survey Shows

Eighty per cent of the American people do not favor a rise in taxes to pay doctors a salary, an authoritative independent survey has revealed.

This was one of the important findings turned up in a comprehensive study done for the American Academy of General Practice by the Opinion Research Corporation of Princeton, N. J. More than a year in work, the just-completed survey was to be reported to the Academy's 27,000 family-doctor members in the February issue of the medical journal, *GP*, by Mac F. Cahal, AAGP executive-director.

Though the survey covers much more than the "no taxes for doctors" finding, Cahal said this revelation

is highly significant in light of President Kennedy's call for passage of the administration's medical care for the aged bill "without delay," last week in his "State of the Union" message to Congress.

Commenting on this Federal plan for financing medical eldercare through Social Security (King-Anderson bill), Cahal pointed out that reactions to socialized medicine or national compulsory health insurance hinge on delicate semantic considerations.

"It seems probable that a great many people would vote for 'free' medical care but, paradoxically, the same people, or at least 80 per cent of them, would not want to pay higher taxes to finance a Federal health care program," the association executive said. "There is no such thing as 'free' medical care, and the Academy feels strongly that congressmen and other politicians should not use this word to deceive the American people.

"Every penny the government spends comes out of the taxpayer's pocket, and it is improper to state or imply that any health care program is 'free,'" he said. "The government can't build a highway, a ship or a bomber without dipping into the taxpayer's pocketbook. It also cannot provide 'free' medical care.

Cahal noted that if the Congress passes such a bill (as King-Anderson), it will mean simply that people under age 65 will be paying for medical care received by people over age 65. The next step, he said, will be to drop the age requirement and enact pure socialized medicine. When this happens, taxes will go up again—and everyone will be paying for medical care —whether he needs it or not.

"In England, a nation that has been in the socialized medicine camp since 1948, health care taxes have gone up and up and up," Cahal said, "Furthermore, people who need surgery often have to wait for months or even years. Consequently, a steadily increasing number of British people are turning to private health care via voluntary health insurance. It certainly is to be hoped the people of this country will profit by Britain's experience."

Survey Explodes Medical Myths

A recent depth study has apparently upset many medical applecart myths.

For example, three-fourths of all American adults are well-satisfied with the quality of available medical care, the opinion survey reveals. Moreover, when asked to list complaints about medical treatment, 54 per cent had none at all. Only 18 per cent thought medical care was "too expensive."

Reporting on an Opinion Research Corporation survey in the February issue of *GP* magazine, Mac F. Cahal, executive director of the American Academy

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S. C. Medical Association

Public Relations Committee

P. O. Box 275, Charleston, S. C.

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☐ Helping Those Who Need Help
☐ Socialized Medicine and You
☐ A Family Doctor's Fight
(A Reprint, *Look Magazine*)

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ADDRESS_____

_____

of General Practice, points out that the study explodes many other popular medical myths—among them the notion that people want socialized medicine. The Opinion Research Corporation, Princeton, N. J., is an independent and nationally known sociologic study group.

More than 80 per cent of those interviewed believe it would be better for individuals to pay their own doctors than for taxes to be raised to pay doctors a salary.

Thus, comments Mr. Cahal, it would appear that four out of five people in the United States are against tax-supported medicine and in favor of the traditional fee-for-service system.

Touching on another aspect of medical finances, those surveyed said that considering the importance of the work they do, physicians deserve a good income. Doctors should be paid for whatever time and skill they devote to a case.

When asked "What do you think is the most important single thing your doctor gets out of being a physician?", only 19 per cent answered "financial gains." More than 63 per cent answered "satisfaction in curing or helping people."

Contrary to popular belief, the general practitioner is *not* on his way out, the ORC reports. Three-fourths of the public call their family doctor first when they need help and believe that good medical care is centered around a particular family physician.

Sheer competence, not the long-touted "bedside manner," is the quality most demanded by today's public. According to the survey, people who buy medical care are no different than people who buy any other service or commodity. Above everything else, they want quality care and prompt results.

In view of this, Mr. Cahal points out, the physician's role as primarily the wise family friend seems on the decline, the horse-and-buggy doctor a thing of the past.

However, three out of five persons interviewed had known their family doctor more than five years. Only three out of 10 had changed doctors within the last five years, and most of these changes were brought about because of a patient's change of residence or the doctor's retirement or death. Only 8 per cent changed physicians because they were dissatisfied.

The Opinion Research Corporation obtained its data from depth interviews with 535 persons, constituting an exact minature replica of the total U. S. adult population.

OFF WITH THEIR MONEY

"If a state does not conform, then we cut off their money" . . . . . This statement was made by Secretary of HEW Abraham Rificoff in Washington, December 11th when he announced administrative changes in the federal-state public assistance program . . . . . The direct quotation appeared in an Associated Press dispatch printed in both Chicago's *American* and *Chicago Sun Times* . . . . . Ribicoff told a news conference that the changes are approved by President Kennedy and are the first steps in a broad program for welfare revision which will cost taxpayers more money . . . . . The threat "If a state does not conform, then we cut off their money" should lay to rest forever the fairy tale, so popular with the socialists, that federal aid does not carry with it federal control . . . . . The new program will add $17,300,000 to welfare costs which now run more than $4 billion a year, with $8,650,000 the federal government's share and the same amount to be paid by the individual states . . . . . Ribicoff said, "I would expect to have cooperation from the states in this"; he added if the states refuse to cooperate "then we get tough . . . . . If the state does not conform, then we cut off their money" . . . . . In the old days of emperors and dictators and other forms of government in which the people had no representation, it was a case of "conform, or off with your heads" . . . . . Civilization apparently has carried us this far: It is no longer "off with your heads", but it is "off with your tax money."

In 1942 a ruling of the Supreme Court declared in effect "that which the government subsidizes it has a right to regulate" . . . . . Since that time honest individuals have recognized that the spending of federal money unquestionably was followed with federal controls . . . . . Nevertheless, the welfare-statists, the do gooders, and all those who seek to impose a government of socialism on the American people have denied that federal aid meant federal regulation and control . . . . . This deliberate misrepresentation has led many of the uninitiated and naive citizens to believe that the federal government could put up money for farm programs, education and numerous other things without the enslavement of federal controls . . . . . This statement by the Welfare Chief, we hope, will convince them that federal controls follow federal subsidization as surely as night follows day . . . . . The only thing nice we can say about Mr. Ribicoff and his statement is that he is "forthright", and apparently is an honest socialist.

Association of American Physicians and Surgeons
News Letter — Jan., 1962

MEDICAL FREEDOM IS YOUR FIGHT. See Page 104.

Deaths

Dr. C. A. Pinner, Sr.

Dr. Caroll Alexander Pinner, Sr., whose long practice of medicine in Fairfield and Newberry counties led to a highway bridge being named for him, died in a Newberry hospital January 25.

Dr. Pinner had lived in Peak since 1914 and had gone by horseback, buggy and auto to reach patients in Fairfield and Newberry counties.

His two-county territory was divided by the Saluda River, and for years a railroad trestle was the only way to cross the river.

Dr. Pinner walked across the trestle and used a second car parked on the other side to reach his patients.

Recently a bridge was built across the Saluda near Peak, and it was named in honor of the 69-year-old physician.

Dr. J. F. Townsend

Dr. John Ferrars Townsend, former head of the department of ophthalmology and otolaryngology at the Medical College of South Carolina, died January 31 at his residence. He was 81.

Born at White Point Plantation near Charleston, Dr. Townsend was graduated from the Medical College of South Carolina in 1903.

After interning in New York and Boston, he practiced general medicine for a year. He then went to London to study the eye, ear, nose and throat specialty in 1907. He then became associated with the Medical College and was made a full professor in 1937.

During World War I, he was a member of the Volunteer Melical Service, Council of National Defense, in charge of eye, ear, nose and throat service at Roper Hospital throughout the war.

He was a fellow of the American College of Surgeons, a member of the Medical Society of South Carolina of which he was president in 1943, the S. C. Medical Association, American Medical Association and the American Academy of Ophthalmology and Otolaryngology.

Dr. Townsend retired from his position on the faculty of the Medical College in 1950.

Dr. G. K. Nelson

Dr. George Kaigler Nelson, 70, Columbia, died at the Baptist Hospital after an illness of several days.

Dr. Nelson was born in Calhoun County. He was a graduate of the Medical College of South Carolina, class of 1915.

During World War I he served in the Army and was stationed in France. After being discharged from the Army Dr. Nelson resumed his practice in Columbia and continued until his leath.

He was a member of the Columbia Medical Society and the South Carolina Medical Association.

Dr. William L. Byerly, Jr.

Dr. William L. Byerly, Jr., 44, chief of surgery at the Byerly Hospital at Hartsville, died January 18 of a heart condition.

He was a past president of the Pee Dee Medical Society.

Born in Hartsville, Dr. Byerly was a graduate of the University of South Carolina, he received his medical degree and served his internship at University of Maryland Hospital in Baltimore.

During World War II, he served in the Army Medical Corps, rising to the rank of captain. In 1948 he returned to University of Maryland Hospital as chief resident of surgery and also instructed in surgery at the school of medicine.

He had been chief surgeon at the Byerly Hospital since 1949.

He was a diplomate of American Board of Surgery, fellow of American College of Surgeons and member of its credentials committee for South Carolina. He was a member of American Medical Association, South Carolina Medical Association, Darlington County Medical Association, Southeastern Surgical Society, South Carolina Surgical Society, and Medical Chirurgical Society of Baltimore.

Active in Boy Scout work, he was on the executive board for Pee Dee Area Council, chairman of its health and safety committee, and past district chairman for Hartsville.

He had served as a director of the American Cancer Society, anl member of Hartsville Community Center Building Commission.

Dr. William H. Breland

Dr. William Henry Breland, 83, died in the Allendale County Hospital January 21.

Dr. Breland was a graduate of the Medical College of South Carolina, after which he did post graduate work in New York City. For more than 50 years, Dr. Breland practiced medicine in Allendale County, first being associated with his father, later with the late Dr. Eric Warnock, and finally practicing alone. For several years he served as health director of Allendale and Hampton counties.

BASIC FACTS ABOUT THE AMERICAN MEDICAL ASSOCIATION

. . . its history, its purpose, its accomplishments.

ITS BEGINNING:

A. M. A. was founded May 5, 1847 in Philadelphia, Pa., by 250 physicians representing more than 40 medical societies and 28 colleges, embracing medical institutions in 22 states. These doctors were concerned about the poor quality of medical education in the United States, about the brisk traffic in patent medicines and secret remedies, and about the lack of a recognized code of ethics. They felt that a national association of physicians was needed to lead the crusade for better medical care. The Association's founder was 30-year-old Dr. Nathan Smith Davis of New York. First president was Dr. Nathaniel Chapman of Pennsylvania.

ITS PURPOSE:

Article II of the Constitution of the A. M. A. reads: The objectives of the Association are *"to promote the science and art of medicine and the betterment of public health."* A. M. A.'s primary goals are better health for all people, and service to the professional needs of the membership.

MEMBERSHIP:

A. M. A. membership includes some 180,000 physicians approximately 70% of the nation's 254,877 licensed physicians. Any physician who is a member in good standing of his state medical society may become a member of the American Medical Association.

ORGANIZATION:

The A. M. A. is a federation of 54 state and territorial medical associations. These in turn are composed of almost 2,000 country or district medical societies. The representative government principle applies throughout, with authority moving up from the country society through the state association to the national body, through the process of elected delegates.

HOUSE OF DELEGATES:

The House of Delegates is the national policy-making body of the medical profession. It is composed of 216 members, most of whom are elected from each state association, on the basis of one delegate for each 1,000 active members of A. M. A. or a portion thereof in each state. The House also includes one representative from each of the 20 Sections of A. M. A.'s Scientific Assembly. This assures representation from every branch of medicine, since one section is devoted to general practice and the rest to the various specialties. The house includes, in addition, a delegate from each of the government services—Army, Navy, Air Force, Veterans Administration and Public Health Service—and two non-voting delegates from the Student A. M. A. Past presidents and certain other officials are also non-voting delegates. The House meets twice annually (in June and December) to establish policies and programs.

OFFICERS:

The President, President-Elect, Vice-President, Secretary-Treasurer, Speaker of the House of Delegates and Vice-Speaker are elected each year by the House of Delegates.

BOARD OF TRUSTEES:

Between meetings of the House of Delegates, the A. M. A. is governed by the Board of Trustees. It is composed of the President, President-Elect, and nine trustees, who are elected by the House from different geographical regions of the country. Each trustee is named for a five-year term and may succeed himself only once. Officers and trustees serve without pay.

HEADQUARTERS STAFF:

The staff to carry out the programs inaugurated by the House of Delegates is headquartered at 535 North Dearborn Street, Chicago 10, Illinois. It is under the direction of the Executive Vice President, a full-time, salaried physician-administrator. There are about 700 persons on the headquarters staff, 13 of whom are in Washington, D. C.

A. M. A. BUDGET:

A. M. A.'s budget is approximately $16 million annually. In 1960, 50.1% of the income came from advertising in A. M. A. publications; 22.8% from membership dues; 14.4% from outside subscriptions; 6.7% from miscellaneous sources; 3% from investments, and 3% from the sale of exhibit space at meetings.

In 1960, expenditures were:

Paper, printing, and mailing costs, 41.7%; *Business Division* (includes departments of accounting, advertising, building services, circulation and records, contract printing, convention services, operation services, and personnel) 16.7%; *Communications Division* (includes editorial preparation of *The AMA News* and *Today's Health* and departments of press relations, medical motion pictures and television, program development, services to officers, and special services) 8.5%; *Scientific Activities Division* (includes work of departments of advertising evaluation, drugs, foods and nutrition, medical education and hospitals medical physics and rehabilitation, mental health, nursing, and scientific assembly) 6.8%; *Executive Vice President's Office* (includes such "employer" expenses as real estate taxes and social security taxes) 8.3%; *Environmental Medicine Division* (includes departments of health education, international health, national security, occupational health, rural health, and Washington medical liaison representatives) 2.7%; *Legal and Socio-Economic Division* (includes departments of economic research, investigation, medical service, law, legislative, medical ethics, legal medicine, and a Washington representative) 4.6%; *Scientific Publications Division* (includes preparation of

editorial content of the *Journal of A. M. A.* and 10 specialty journals and departments of archives-library, research and documentation in medical journalism, and standard nomenclature) 4%; *Field Service Division* (includes the field representatives and three legislative representatives in Washington) 1.5%; *Board of Trustees* (finances meetings of various A. M. A. councils and committees which are advisory to the Board and to the House of Delegates) 4.5%; *Washington Division* (includes work of the office and its staff except those members attached to other divisions) 0.7%.

PUBLICATIONS:

Publications are a highly important facet of A. M. A.' program. Since 1883 the *Journal of the American Medical Association* has been the most widely circulated medical journal in the world.

To meet the needs of the medical specialties, A. M. A. publishes 10 monthly specialty journals:

Archives of General Psychiatry, Archives of Dermatology, Archives of Otolaryngology, Archives of Environmental Health, Archives of Pathology, Archives of Surgery, Archives of Neurology, and *American Journal of Diseases of Children.*

In the non-scientific publications field, the A. M. A. publishes *Today's Health,* a monthly consumer magazine, and *The AMA News,* a fortnightly medical newspaper which reaches more physicians than any other medical publication.

Periodically the A. M. A. publishes the *American Medical Directory,* undisputed reference of the medical profession, giving biographical and educational information about all licensed physicians in the U. S. This volume was first published in 1906.

Annually A. M. A. publishes cumulated *Index Medicus,* an index to medical books and periodical literature published throughout the world. This publication gives permanence to the medical literature of today, carrying forward the knowledge of this generation to the scientific workers of the ages to come.

New and Nonofficial Drugs, a book published annually, contains a compilation of available information on drugs, including their therapeutic, prophylactic and diagnostic status, as evaluated by A. M. A.'s Council on Drugs.

The lengthy list of A. M. A. publications, including pamphlets, reprints, and reports, earns for the Association the title of one of the world's leading scientific publishers.

SCIENTIFIC MEETINGS:

A. M. A.'s Annual and Clinical meetings, held each June and December, are the most important postgraduate medical study sessions in the world. The meetings encompass some 400 scientific lectures; between 350 and 400 scientific exhibits; 300 to 400 industrial exhibits illustrating new drugs, equipment and books; outstanding scientific films and special closed circuit television presentations.

In addition throughout the year there are many seminars, symposia and other meetings of a postgraduate nature on specific topics.

COUNCILS, COMMITTEES:

A. M. A. makes one of its greatest contributions to medicine by gathering data on new products, new findings, and new methods—correlating, evaluating, and summarizing it—and channeling it to members.

A number of scientific councils and committees, each composed of leading physicians serving without remuneration, carry on this work with the aid of headquarters staff. Between 700 to 800 physicians, representing every section of the country, serve on these councils and committees.

The A. M. A. councils on drugs, foods and nutrition, medical education and hospitals, medical physics, medical service, mental health, national security, occupational health, rural health, legislative activities, constitution and bylaws, scientific assembly and judicial matters.

There are A. M. A. committees on cosmetics, medical aspects of automobile injuries, medical aspects of sports, medical practices, medical rating of physical impairment, liaison with national nursing organizations, medicolegal problems, voluntary health agencies, aging, federal medical services, indigent care, insurance and repayment plans, maternal and child care, medical facilities, alcoholism, hypnosis, narcotic addiction, disaster medical care, military medical affairs, aerospace medicine, fractures and other equally important subjects.

In addition there are 17 residency review committees covering the various specialities, liaison committees and advisory committees in various fields.

SCIENTIFIC ASSEMBLY SECTIONS:

These include anesthesiology; dermatology; diseases of the chest; experimental medicine and therapeutics; gastroenterology and proctology; general practice; general surgery; internal medicine; larynology; otology and rhinology; military medicine, nervous and mental diseases; obstetrics and gynecology; ophthalmology; orthopedic surgery; pathology and physiology; pediatrics; physical medicine; preventive medicine; radiology; urology.

LIBRARIES AND RECORDS

A. M. A.'s medical library is comprised of an International collection of some 1,600 periodicals on basic medical science and clinical medicine and nearly 200,000 pamphlets and reprints. It offers free to members a periodical lending service and package library service.

A. M. A. also "reads" hundreds of foreign medical journals for physicians, abstracting significant articles.

The Association maintains a medical film library of more than 250 subjects and has the largest source file of medical films in the U. S.—more than 2,500 indexed references.

A. M. A.'s Department of Investigation has one of the largest collections of nostrums and quack gadgets and medicines in the U. S. and maintains the largest files existent on medical quackery.

A. M. A.'s records department keeps complete records on all licensed physicians. These information files are begun as soon as a student enters medical school and are kept for some years after a physician's death. These records are the most complete of any profession.

The Association also maintains an extensive library of legal briefs on medicolegal cases plus other medico-legal information and materials.

Other A. M. A. departments have films, exhibits, and extensive files on specific subjects.

WHAT THE A. M. A. DOES:

A. M. A. is a non-profit, public service institution, organized to protect the public health and to promote the highest quality medical care for the American people. It helps physicians keep up to date on every phase of modern medicine and serves the American public in a thousand unseen ways each day.

The Association's activities are many and varied.

To help physicians in their practice of medicine, the A. M. A. . . .

Provides early unbiased information on all types of new drugs . . . evaluates physical methods and apparatus intended for the diagnosis, treatment and prevention of disease . . . sponsors two huge post-graduate meetings annually and many special symposia and conferences . . . publishes 11 scientific journals and a medical newspaper . . . maintains a physicians' question and answer service . . . works for higher standards of internship and residency training . . . exerts leadership to solve medical problems as they arise and serves as a vast clearing house on scientific medicine . . . studies the ever-increasing problems related to the non-scientific side of medicine, probing questions and developing action programs . . . maintains extensive libraries and library lending services . . . provides office planning guides and practice aids . . . studies and reports on patterns of practice . . . publishes pamphlets for distribution to patients . . . serves as clearing house for information on state legislation of medical interest, and analyzes medical legislation introduced in Congress . . . keeps up-to-date records on all physicians . . . offers scores of other services designed to keep the physician abreast of the times and to help him practice the best medicine.

A. M. A. assures high-calibre medicine by . . .

Waging constant war on medical quackery, helping educate the public about dangers of quackery and serving as source of information to government agencies and others to help bring quacks to justice . . . inspecting medical schools periodically, evaluating curriculum, teaching staff, physical and clinical facilities and administration to maintain high standards in medical schools . . . cooperating with Joint Commission on Accreditation of Hospitals to maintain high hospital standards . . . promoting research . . . encouraging adherence to highest standards of medical ethics . . . initiating or supporting legislation which is in the best public interest opposing legislation which in its opinion would result in lower qualty health care.

A. M. A. serves the public by . . .

Studying usefulness, limitations and health problems of cosmetic preparations . . . evaluating foods and special food products, pesticides and chemicals to assure safety . . . getting physicians into small communities and rural areas via placement service . . . answering between 12,000 and 15,000 personal letters on health subjects each year and using every medium of communications in its health education program for the public . . . inviting interested representatives from the public to attend conferences on rural health, industrial health, and school health . . . maintaining loan collection of health exhibits and films . . . encouraging high standards in advertising and labeling of foods and drugs . . . working closely with schools and educators to help provide for pupils' health needs . . . conducting public educational campaigns on traffic safety, use of seat belts, ways to reduce accidental poisonings and accidents and many other subjects . . . working with industry to control health hazards on the job, rehabilitation of disabled workers . . . alerting the public to the importance of preparing for any emergency resulting from a national disaster . . . helping rural communities improve their health environment . . . developing standards for nursing homes to assure safe care for patients . . . publishing *Today's Health* magazine . . . producing films, radio transcriptions, TV shows and exhibits on health subjects . . . serving as a watchdog of medical standards.

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Book Reviews

THE CARDIAC ARRHYTHMIAS by Brendan Phibbs, M. D. The C. V. Mosby Company, St. Louis, 1961. 103 pages. Price $7.50.

This is a brief and elementary treatment of the cardiac arrhythmias which is well illustrated with diagrams and electrocardiograms. At the end of the text is a short section devoted to exercises in interpretation of arrhythmias and an index.

The book is good as far as it goes, but it does not go very far. It has been designed as a guide to the general practitioner and might help him to a better understanding of the arrhythmias, but would certainly not be adequate as a textbook on the subject.

John A. Boone, M. D.

APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY, by John Adriani, M. D., Editor. First Edition. The C. V. Mosby Company, St. Louis. 1961. $7.00.

This book represents a tremendous amount of work in gleaning from the current literature a mass of information and current ideas about the new and old concepts in anesthesiology. It is well written, concise, and to the point in each one of the chapters which are represented. A mass of invaluable information is assembled in regard to altered physiology, and most of the complications which one runs into with many different types of anesthesia and surgery. Ideas are presented in which the actions and effects of different drugs, ranging from hypotensive agents through antibiotics, have on the body during normal life and in different diseased states.

Both the anesthesiologist, the surgeon, and the anesthetist will find this a book of valuable information.

Laurie L. Brown, M. D.

INTRODUCTION TO ANESTHESIA, by R. D. Dripps, J. E. Eckenhoff, L. D. Vandam. 2nd Edition. W. B. Saunders Company, Philadelphia—London. 1961. $8.00.

This book is exactly as stated on the cover, an introduction to anesthesia, and the principles of safe practice. It is an excellent book for beginners in anesthesia and also for a review of some of the fundamentals for those who are experienced in the field. It is well written, covering the very important preoperative care of patients as well as the complete induction of anesthesia, types of anesthesia, techniques, records and pitfalls which one might encounter. The reader will find basic concepts of physiology, the fundamentals of resuscitation, both respiratory and cardiac, and the general principles which should be followed in taking care of a patient under all types of anesthesia.

There is a section which is very important in anesthesia but is often overlooked, and this is asepsis in care of equipment, anesthetic agents, etc.

I think that this book is a good addition to the anesthesia library.

Laurie L. Brown, M. D.

AN ATLAS OF BRONCHOSCOPY. A. Huzly, M. D. Grune & Stratton, Inc. New York 1961. $12.50.

This atlas has much to commend it. It is well-organized and comprehensive. The photographic illustrations are excellent and each illustrates well the pathological condition presented.

The camera used and the proximal distal lighting by means of a quartz rod is particularly well-suited for endoscopic work. Both movies and stills are taken by this method.

The method of presenting a written description of the pathological condition in the bronchus in one section of the book and then, in another section giving the photographic presentation of these conditions with an accompanying brief description is unique and quite effective.

Dr. Huzly is eminently qualified to be the author of an atlas concerning bronchoscopic pathology as he has had a wealth of material under his supervision in the last ten years on the continent.

We take pleasure in commending this book to the attention of the serious student of bronchoscopy.

R. W. Hanckel, M. D.

RESPIRATION IN HEALTH AND DISEASE by R. M. Cherniack and L. Cherniack. W. B. Saunders Co., Philadelphia, Pa. 1961. $10.50.

The authors of this volume, assistant professors of medicine at the University of Manitoba School of Medicine, have presented in well integrated form clinical pulmonary physiology, pathophysiology and clinical findings in the various disorders which affect the lungs. The book is arranged in four parts—a section on pulmonary physiology and function, a section on signs and symptoms in chest disease, a section on the pathophysiology and clinical picture of the disorders that affect the lower respiratory tract, and a section on the assessment of respiratory disease including clinical, radiologic, clinical-pathological and pulmonary functional aspects. Pertinent features of the anatomy and physiology of the thorax and its contents are pointed out where knowledge of such aspects of chest disease is helpful. The clinical approach to pulmonary disorders presented in this volume adds greatly to its value for teaching. The most impressive features of this book are its readability and the excellent organization and integration of the various aspects of pulmonary disease. In the opinion of the reviewer it is an excellent book for students, for

teaching clinical pulmonary disease and for physicians in refreshing and clarification of frequently seen pulmonary disorders, and can be highly recommended.

K. McK.

HANDBOOK OF SURGERY, Wilson and McDonald. Lange Medical Publications, Los Altos, California. 1961. $4.00.

This small book succinctly embraces most of the pertinent current surgical problems with a special emphasis on pre and post-operative management. Basic diagnostic information and therapeutic measures of general surgical interest are nicely outlined, and the surgical subspecialties, especially neurosurgery and urology, and thoracic surgery, are well-covered. The tabulated data throughout the book is well organized, diagrams are adequate, and typographical errors have been kept to a minimum; the organization and presentation is good, and the print, although small, is sharp and legible. This text would seem to be the best of the handbook type and is recommended as a ready reference for medical students, house officers, and practitioners.

Richard G. Price, Jr., M. D.

MECHANISMS OF DISEASE—Introduction to Pathology. Ruy Perez-Temayo, M. D. W. B. Saunders Co., Philadelphia. 1961. $14.00.

Dr. Perez-Temayo states in the introduction of his book that the stages of medical education are (1) The general principles where the student is presented with a broad view of the mechanisms of disease; (2) The analysis of specific disease entities; (3) The study of patients as isolated instances of different ailments. His book was written with the purpose of presenting in a single volume, a general survey of the mechanisms of disease, and as a guide during the first phase of the study of pathology. The first part of his book consists of a scholarly review of the degenerative and regressive disturbances of cells and tissues, inflammation, repair degeneration and tissue transplantation, disturbances of growth and differentiation of tissue in the pathology of tumors.

In the second part of his book he reviews the general pathology of connective tissues, the host-parasite relationship, the immune response, and the general pathology of body fluids and electrolytes. He also discusses the general pathology of metabolism and nutrition in the nature of disease.

The first section of the book deals with basic processes of pathology, reviewing in detail the phenomena that the student of pathology might take for granted such as cloudy swelling, fatty infiltration, and hyaline degeneration.

Part two of the book is of some interest in itself, but seems to be well covered in other texts of pathology. Dr. Perez-Temayo's concept is somewhat broader, and he includes physiologic and biochemical detail when it is pertinent in addition to the usual pathologic and histologic discussion found in most standard texts.

The section on general pathology of body fluids and electrolytes is a condensation of the immense basic work done in this field and is much better covered in other texts related to this area.

In general, Dr. Perez-Temayo's attempt to consolidate all of the basic mechanisms of disease into one volume falls short of its goal. However, it is an excellent book for collateral reading for the beginning student of pathology or as a review of pathology for the interested clinician.

Arthur V. Williams, M. D.

THE CERVIX UTERI AND ITS DISEASES. C. Frederick Fluhmann, M. D., W. B. Saunders Co., Philadelphia. 566 Pages. 1961. Price $14.00.

This is a reference work on the anatomy, histology, physiology, cytology, and pathology of the cervix uteri. In general, treatment of cervical lesions is brief except for invasive carcinoma of the cervix. Treatment of invasive carcinoma occupies 110 pages or 1/5 of the book; however, the illustrations in this section are quite informative as regards radiotherapy and radical hysterectomy.

In general, this excellent reference work will be used by physicians interested in gynecology, and more particularly, carcinoma of the cervix. Its completeness is exemplified by the chapter on fungus, parasitic, and unclassified cervical inflammations which contain illustrations of unusual and rarely encountered cervical lesions. Mention must be made of the photographs, microphotographs, drawings, and tables which are excellent and contribute much to the value of this treatise on the cervix uteri.

Lawrence Hester, M. D.

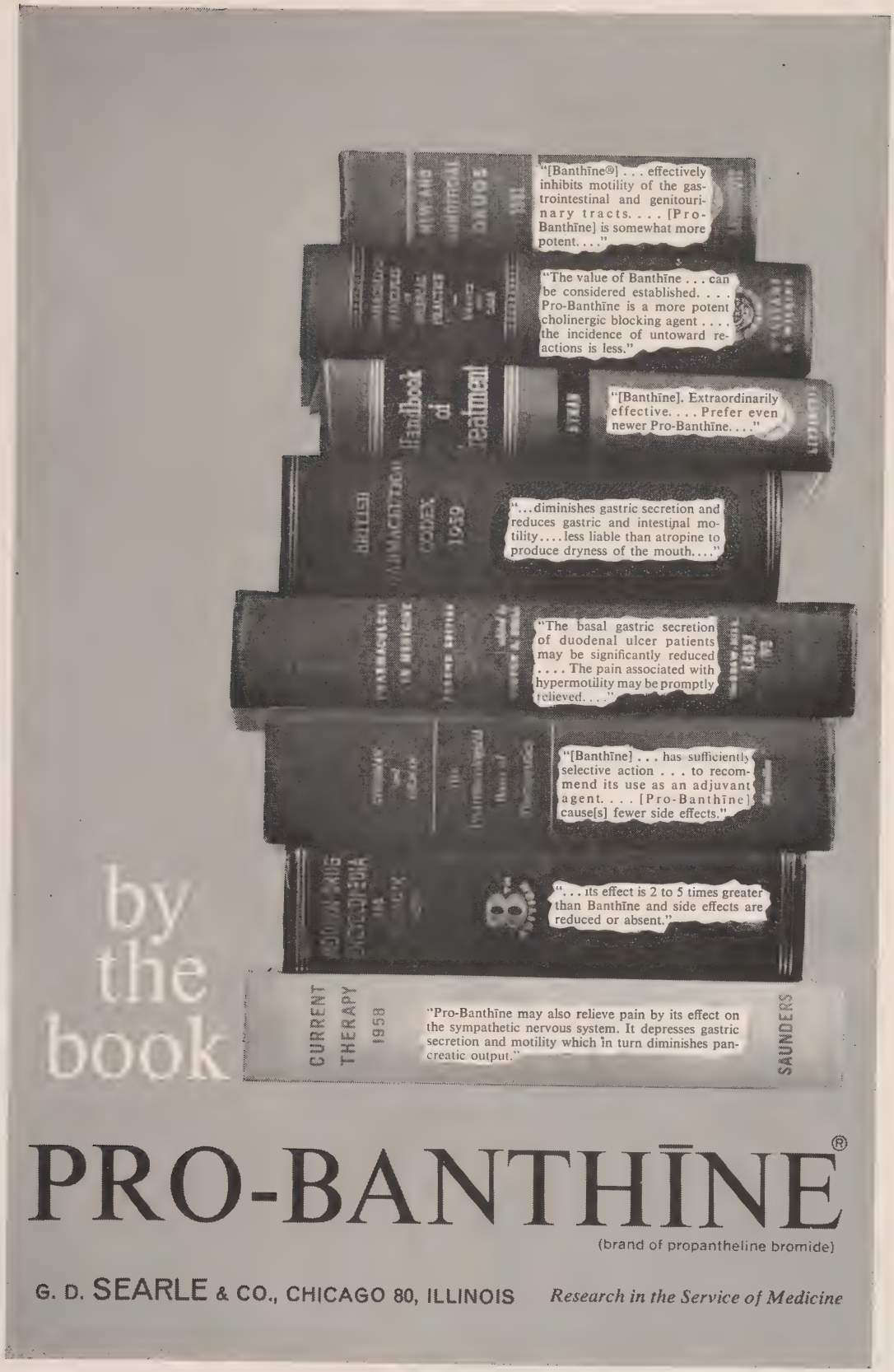
DISTURBANCES OF HEART RATE, RHYTHM AND CONDUCTION. Eliot Corday and David W. Irving. W. B. Saunders Company, Philadelphia, 1961. $8.50.

This appears to be a systematic, well illustrated and conservative discussion of the diagnosis and treatment of cardiac arrhythmias. Very good diagrams are included in explanation of the physiological mechanisms involved and the general treatment of the subject seems reasonably complete. It would fall more into the category of a textbook of arrhythmias than that of a handbook for the practitioner.

John A. Boone, M. D.

PATHOLOGY, edited by W. A. D. Anderson. 4th Edition. The C. V. Mosby Co. St. Louis. 1961. Pp 1389. Price $18.00.

The fourth edition of this well-known text of pathology succeeds in the avowed purpose of giving thorough coverage of the subject within the confines of a single volume. Although useful as a basic text for students beginning their study of pathology, the work achieves its greatest value as a general source of reference for the more advanced student, intern, resident and practitioner. Pathologists have found previous editions, and will find this one, a valuable reference tool in the general field.


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The fourth edition differs from earlier editions in some important aspects. First of all new chapters have been added. One of these concerns hypersensitivity and the so-called collagen diseases. It is written by Howard C. Hopps and is a valuable addition reflecting the growing interest and rapid strides made in this area. The mesenchymal tumors of soft tissues are the subject of another new chapter by Richard Shuman which fills the noticeable void of the earlier editions. Here the various tumors and proliferative processes of fibrous tissue are well reviewed and clearly presented. The more recent classification of rhabdomyosarcomas is given including the alveolar form, and tumors of heterotopic bone and cartilage are given consideration. Both new chapters are welcome additions to the text with evident practical value.

Other noticeable changes include revisions and additions to other chapters having the result of bringing many of these areas up to date. Advances brought about through the application of electron microscopy and histochemistry to the field are included where indicated. Several new illustrations along these lines appear. Discussion of many newly recognized syndromes are included; in particular the carcinoid syndrome, aldosteronism and pulmonary alveolar proteinosis. In general, these revisions are pertinent and lucid.

The various contributors have worked diligently to incorporate new advances, and have presented the material with clarity. The fourth edition of W. A. D. Anderson's Pathology is considered a very valuable contribution.

T. M. P.

ESSENTIAL HYPERTENSION, AN INTERNATIONAL SYMPOSIUM. Edited by K. D. Bock and P. T. Cottier. 392 pp. Springer-Verlag Publishers, Berlin, Gottingen, Heidelberg, 1960.

There are always formidable problems in compiling into book form the recorded papers and discussions spoken at a medical meeting. Somehow in print many extemporaneous contributions just don't look as credible as they may sound under the spell of the moment. Additionally, much of the illustrative material projected as slides at the meeting does not find its way to the publisher so that the reader must wade through much explanation without the privilege of seeing what is being explained. One cannct say that this book surmounts all these obstacles but it is a well organized, lengthy and detailed compilation of the proceedings of this conference in which some forty authorities from all over the world participated. As such, it is a reasonable substitute for attending the conference and sets forth a wide diversity of opinion as to the causes, treatment and research on what has been called "the great white plague", hypertension.

On the positive side, there are some excellent manuscripts collected together in this book which one perhaps could not find in any other volume. The contribution of Dr. I. H. Page extolling his mosaic theory of hypertension is worth the price of the book alone. And certainly many of the differences of opinion brought out in the open discussion are provocative, occasionally a pleasant diversion from too many cut and dried medical papers. For example, the following:

"REUBI (to Pickering): You do not agree?

PICKERING: Oh, I do not agree at all, no.

REUBI: Can you quickly say why?

PICKERING: Well, I feel if we are talking about, or if we are going to define, essential hypertension we ought to mean the high pressure and its consequences and not something different. Is a large left ventricle a consequence of high pressure or of something different?

REUBI: I think most of us believe that hypertension is really a disease.

TAQUINI: I would not.

REUBI: I know. But if we try to define this disease, it is a very difficult task, because we do not know its cause and there is no general agreement on the normal limits of blood pressure. Therefore I understand why . . . . .".

I think that this book is a fair statement of the state of our knowledge of essential hypertension as of 1960. It is also a forceful reminder to the clinician that as yet far more is unknown than is known of the basic mechanisms underlying this devastating disease.

Dale Groom, M. D.

DIFFERENTIATION BETWEEN NORMAL AND ABNORMAL IN ELECTROCARDIOGRAPHY by Ernst Simonson, M. D. The C. V. Mosby Co. 328 pages. $13.50.

This book is an accumulation of electrocardiographic data on normal adult subjects. It is a most informative compilation attempting to get the answer to what is a normal electrocardiogram. The literature is well reviewed and is covered along with the statistical analysis of the normal segments of the electrocardiogram. However, the extensive review of the literature with statistics does produce some confusion to the reader. In addition to the normal resting electrocardiogram, the normal is also defined in response to a variety of stress tests. Many of the limits of the vectorcardiogram are also included. The usual aspects of electrocardiography as abnormal rhythms and infarctions are not discussed. This book is at present the ultimate in defining the normal electrocardiogram. However, it is not intended for student use or for the average general physician but is of importance especially to the cardiologist and internist who are extremely interested in electrocardiography.

P. C. Gazes, M. D.

Socialism Is The Goal

Secretary of Health, Education and Welfare Abraham Ribicoff's challenge to the American Medical Association regarding assistance to elderly sick persons is most interesting. On the surface, Mr. Ribicoff offers to let the medical profession handle the job if it can, the federal government keeping hands off if possible.

But, says leftist commentator Edward P. Morgan, what Mr. Ribicoff really means is that AMA should supplement, not provide a substitute for, federal action. In other words, no matter what private medicine does or does not do, big government should enter the picture.

Never has the cat been more clearly let out of the bag. What the Kennedyites are really after is socialized medicine, needed or not. It is the socialism involved that matters, not the needs of unfortunate old people. Here is as clear a commentary on the motives and integrity of the Administration as one could ask.

Forewarned is forearmed. The AMA should tell the government to go hang in this and future proposals. Nothing the federal government has to suggest or offer concerning medical care can be acceptable to those who believe the practice of medicine should be kept private. Negotiation with any socialist is like negotiation with that particular variety of socialist called communist. It is always just a matter of deciding how much you are going to surrender.

Charleston News and Courier, February 3, 1962.



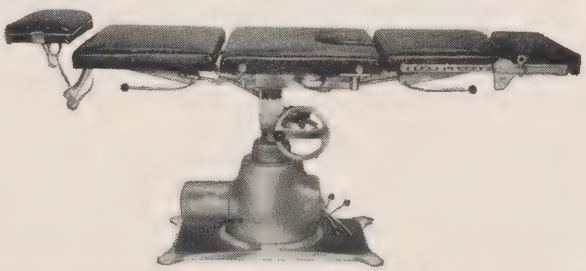
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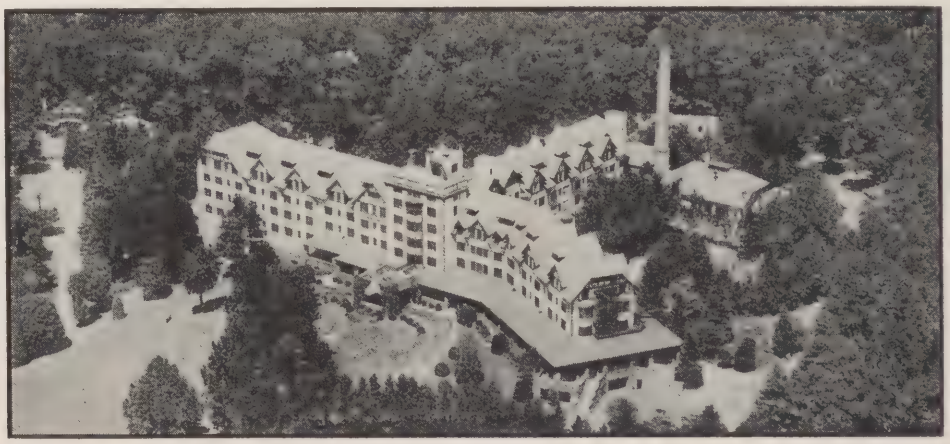
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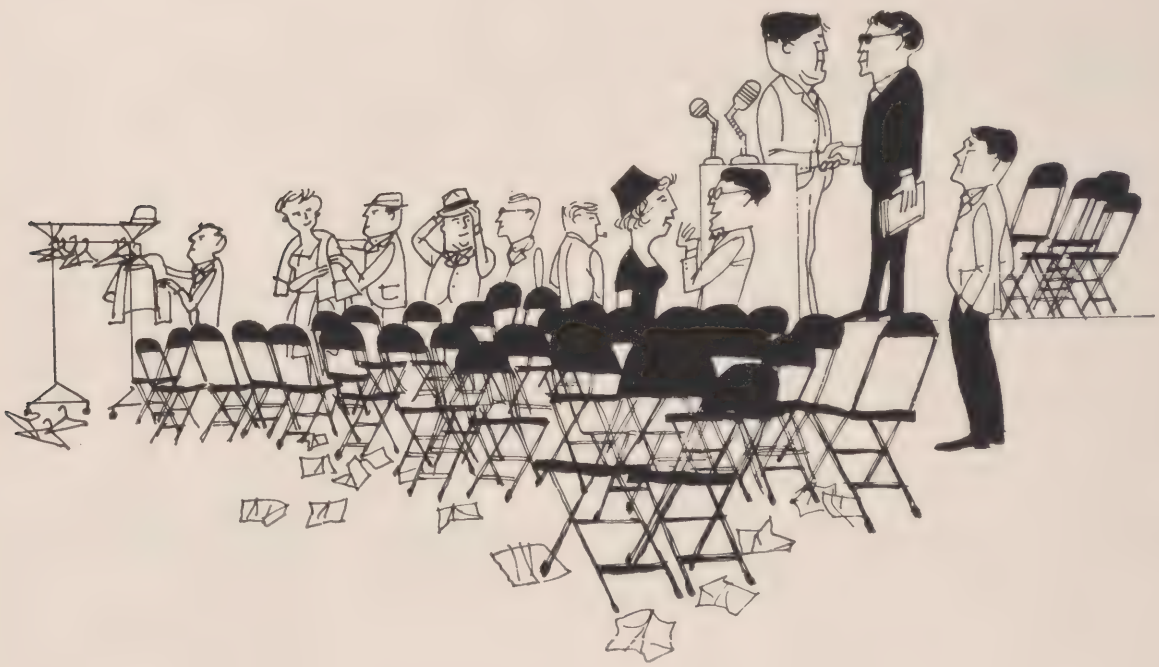
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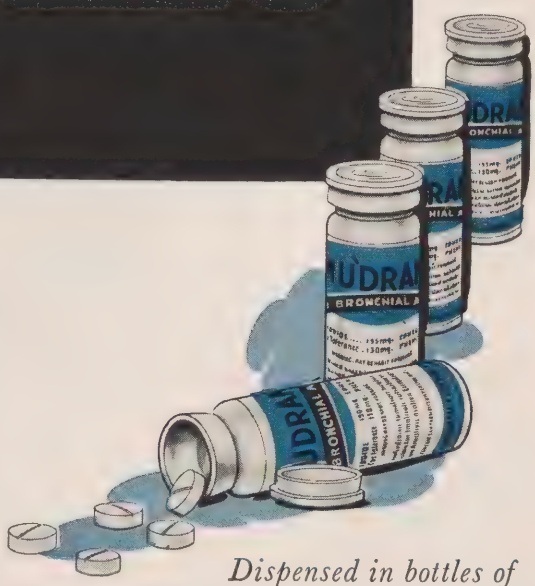


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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

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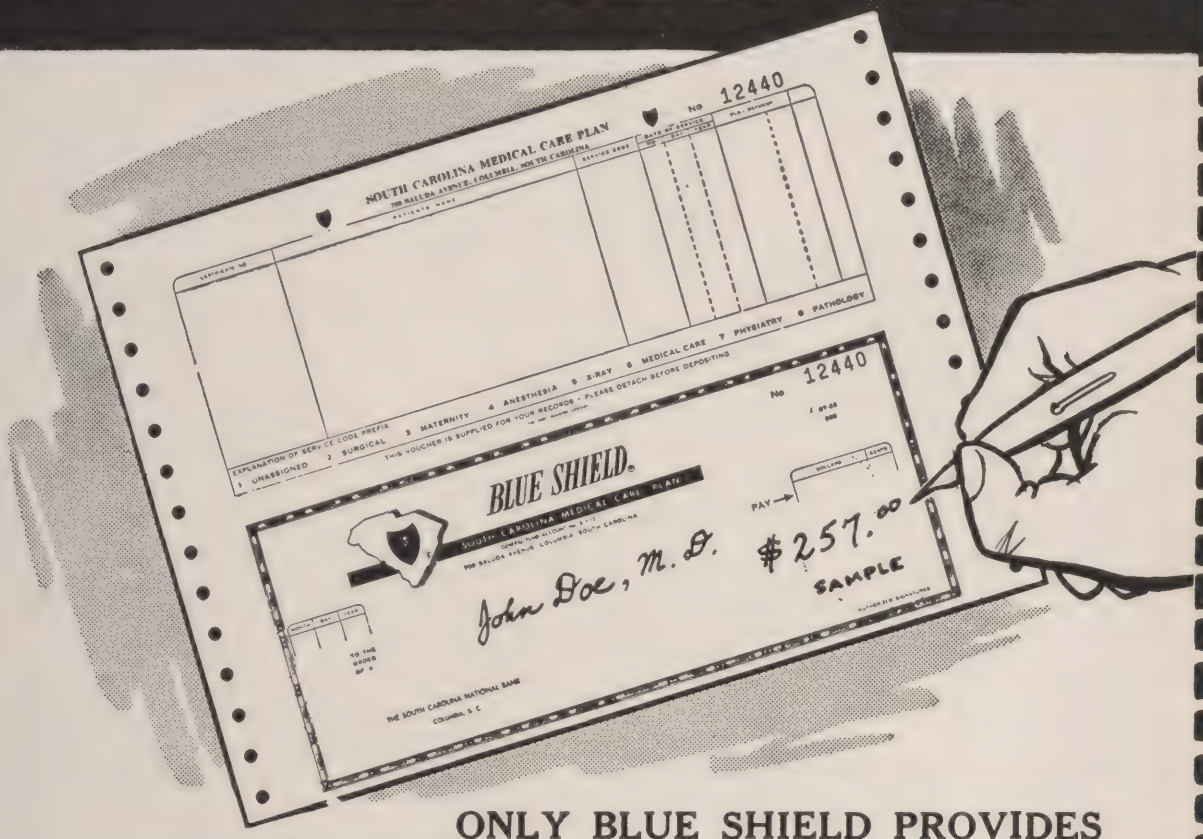
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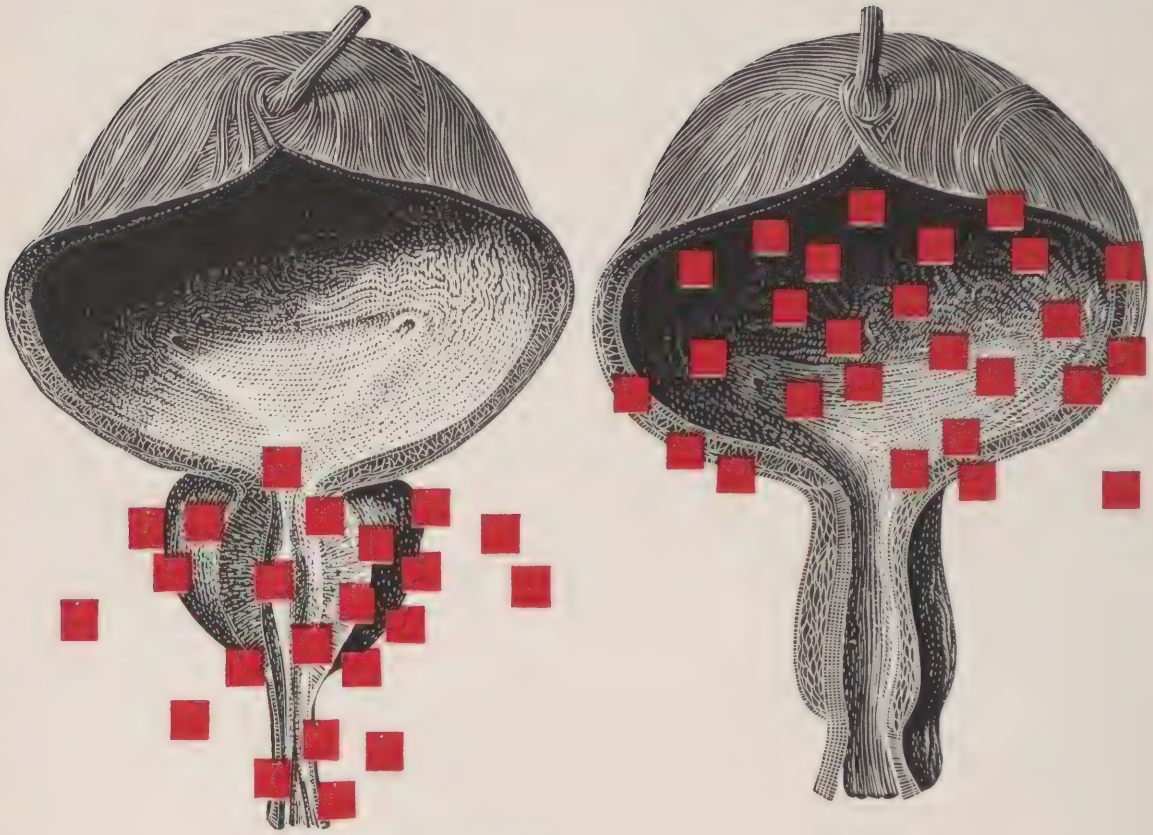
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At real savings to your patients

Serenium provides **quick, localized analgesic action** in acute and chronic urinary tract infections with **only 1 tablet** t.i.d. Your patient is assured of the prompt action of Serenium by the harmless orange-red color of the urine; and he will feel good about the **low prescription cost,** too.

Supply: Bottles of 50 and 500 chocolate-covered tablets. Each tablet contains 0.1 Gm. of Squibb Ethoxazene. For full information see your Squibb Product Reference or Product Brief.

Serenium® is a Squibb trademark.

SQUIBB *Squibb Quality—the Priceless Ingredient*

SQUIBB DIVISION Olin



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

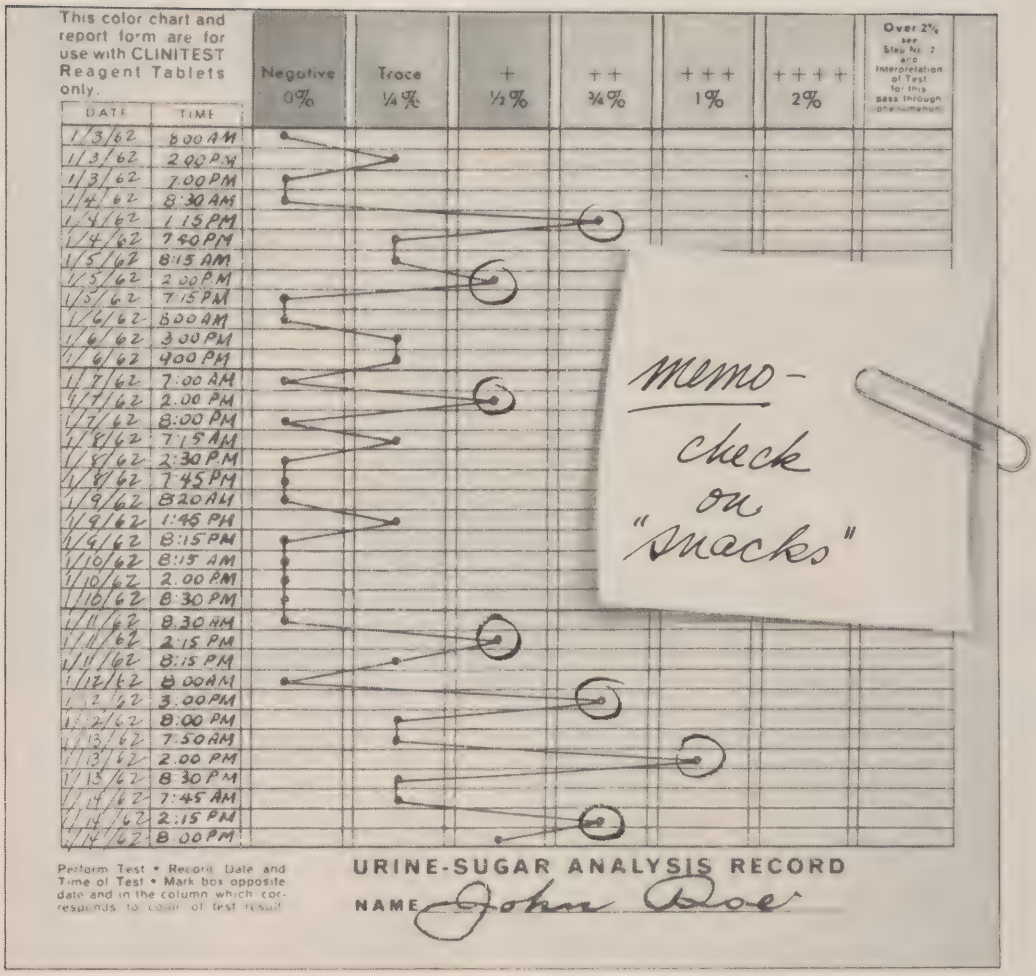
SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

AN AMES CLINIQUICK®

CLINICAL BRIEFS FOR MODERN PRACTICE



in the regulation of diabetes...
GET THE FACTS YOUR PATIENT FORGETS

With graphic ANALYSIS RECORD—"Records of urine tests done at home are essential in the regulation of diabetes." Ricketts, H. T., and Wildberger, H. L.: *Diagnosis and Management of Diabetes Mellitus in General Office Practice,* M. Clin. North America *45*:1505, 1961.

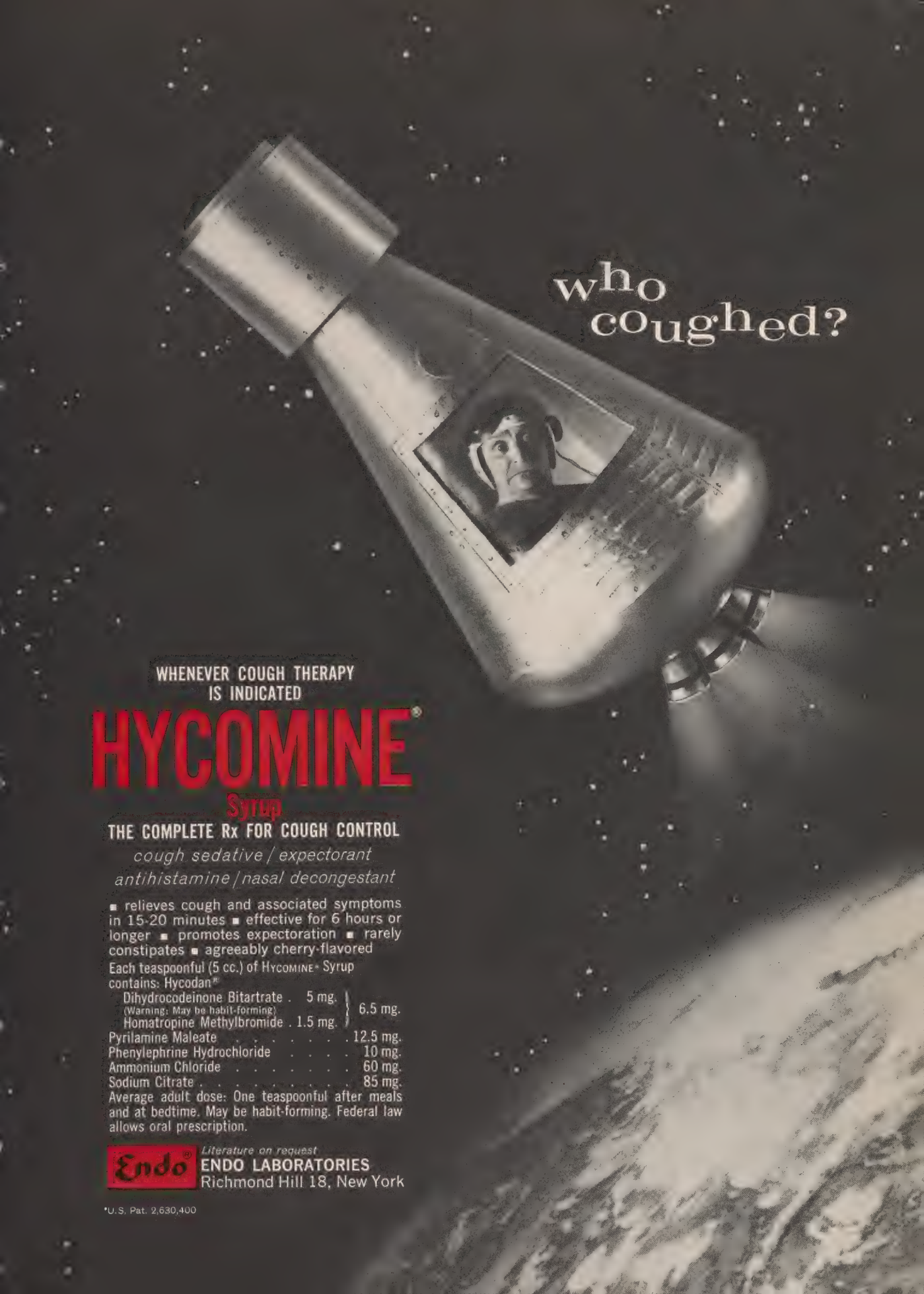
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CLINITEST® BRAND *Reagent Tablets*

quantitative urine-sugar test—for patients whose diabetes is difficult to control, and in therapeutic trial of oral hypoglycemic agents.

Available: CLINITEST *Urine-Sugar Analysis Set* (36 Reagent Tablets)—compact, ready-to-test any time, any place. Set, refills of 36 bottled and 24 Sealed-in-Foil tablets contain *Analysis Record* forms. 19962

AMES
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WHENEVER COUGH THERAPY
IS INDICATED

HYCOMINE®

Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / expectorant
antihistamine / nasal decongestant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains: Hycodan®

Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law allows oral prescription.

Literature on request
ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,630,400

WHAT DO YOU SAY TO A KID WHO CAN'T WALK?

For her, learning to walk is hard, hard work. Sometimes she cries.

Usually you can josh her along. But words don't always help. So you love her—until she gets her fight back. Then she's ready to try again.

Love is one of three things that help a crippled child walk. The other two are *skill* and *money*.

We've found people with love and skill to give, like the Easter Seal therapist in the picture.

We're looking to you for the money. Not a lot—just enough to put one kid one day closer to walking.



"Fight with them—against crippling"

EASTER SEAL FUND APPEAL

Textbook after textbook, article after article and experience in practice after practice consistently have demonstrated the capacity of Demerol to produce satisfactory analgesia without weakening the intensity of uterine contractions. In fact, many observers have reported an apparent shortening of labor, particularly in the primipara.

Because it is well tolerated by both the mother and the newborn child, Demerol is generally considered one of the safest analgesics for use in obstetric practice.

In addition to satisfactory analgesia, a moderate sedative effect is obtained with large doses, and sleep is frequently induced between pains.

In 13,000 deliveries reported by 158 physicians, "Demerol was unquestionably the narcotic of choice during labor."

(Questionnaire, The Maternal and Child Welfare Committee, South Dakota State M. A., 1958)[1]

"Demerol is our drug of choice for analgesia during labor."

(Posner, Fielding and Posner, Harlem Hospital, New York City)[2]

Demerol in combination with scopolamine ". . . offers the best means of securing analgesia and amnesia in labor with the least risk to the mother and child. . . . Often one is amazed at the manner in which the cervix melts away under this form of medication."

(Beck and Rosenthal, State University of New York)[3]





COMFORT—*with Safe Control—in Millions of Patients*

DEMEROL®

THE ANALGESIC OF CHOICE IN OBSTETRIC PRACTICE

Winthrop LABORATORIES • New York 18, N. Y.

For a Smooth Delivery...

DEMEROL®

BRAND OF MEPERIDINE HYDROCHLORIDE

THE ANALGESIC OF CHOICE IN OBSTETRIC PRACTICE



DEPENDABLE ANALGESIA AND AMNESIA

Demerol with Scopolamine

"When combined with scopolamine, it [Demerol] can produce satisfactory amnesia-analgesia in over 90% of the mothers during labour."

(Hershenson and Reid, Boston Lying-in Hospital and Harvard M. Sch.)[4]

In one of the most commonly used technics, an initial dose of 100 mg. of Demerol and 1/150 grain of scopolamine is given intramuscularly when labor is established. Subsequently, 100 mg. of Demerol are given every four hours and 1/200 grain of scopolamine every three hours. "Within 15 or 20 minutes the pain is relieved and neither the frequency nor the intensity of the uterine contractions are diminished."

(Beck and Rosenthal)[3]

Demerol is "... an analgesic drug which relieves pain about as well as does morphine, and it has in addition an antispasmodic action which makes it a good preparation for use during labor. . . . It may be given alone but its effect is enhanced when it is used in combination with scopolamine, and the resultant amnesic effect is excellent."

(Titus, Pittsburgh)[5]

SIDE EFFECTS AND CONTRAINDICATIONS: Demerol hydrochloride is generally well tolerated and nontoxic in therapeutic doses. Side effects occur more frequently in ambulatory patients (who should therefore be specially cautioned) than in those confined to bed. Dizziness is the most common reaction. Nausea or vomiting occurs less frequently than after administration of morphine. Flushing of the face, sweating and dryness of the mouth are sometimes noted. More severe reactions are characterized by great weakness, syncope, profuse perspiration, marked dizziness, and nausea and vomiting. They usually can be prevented if the patient lies down promptly at the onset of side effects. Tolerance to side effects usually develops quickly if medication is continued in small doses (25 mg.). In contrast to morphine, respiratory depression occurs infrequently. However, in patients with lesions that cause increased intracranial pressure, respiratory depression has been noted; therefore, the drug is considered to be contraindicated in such persons.

When Demerol with Scopolamine is used, idiosyncrasy to scopolamine may be encountered occasionally, producing the paradoxic effect of excitement, restlessness, hallucinations and delirium instead of sedation and amnesia. In addition, edema of the uvula, glottis and lips may be encountered occasionally in extremely hypersensitive patients.

Nalorphine (Nalline®) or levallorphan (Lorfan®) are considered to be specific antidotes against respiratory depression which may result from overdosage or unusual sensitivity to narcotics including Demerol.

1. Ranney, Brooks: *South Dakota J. Med. & Pharm.* 11:479, Dec., 1958.
2. Posner, L. B.; Fielding, W. L., and Posner, A. C.: *Obst. & Gynec.* 2:81, July, 1953.
3. Beck, A. C., and Rosenthal, A. H.: Obstetrical Practice, ed. 7, Baltimore, The Williams & Wilkins Company, 1958, pp. 1029, 1030.
4. Hershenson, B. B., and Reid, D. E.: *Bull. Narcotics* 8:36, July-Sept., 1956.
5. Titus, Paul: The Management of Obstetric Difficulties, ed. 5, St. Louis, C. V. Mosby Co., 1955, p. 617.

PRINTED IN U. S. A. REVISED DECEMBER 1961 (1633M)

DEMEROL Hydrochloride Solutions / *for Parenteral Use:*

50 mg. per ml.: Ampuls of 0.5, 1, 1.5 and 2 ml. (25 to 100 mg.); vials of 10 and 30 ml.; disposable syringes of 1 ml.

75 mg. per ml.: Disposable syringes of 1 ml.

100 mg. per ml.: Ampuls of 1 ml.; vials of 20 ml.; disposable syringes of 1 ml.

pH of Demerol 5% and 10% solutions in ampuls and vials is adjusted between 4.5 and 6.0 with sodium hydroxide or hydrochloric acid. Multiple dose vials of Demerol solution also contain metacresol 0.1 per cent as preservative.

Demerol with Scopolamine (50 mg. of Demerol HCl and 1/300 grain of scopolamine HBr per ml.): Ampuls of 2 ml.; vials of 30 ml. pH is adjusted between 4 and 5 with sodium hydroxide or hydrochloric acid.

DEMEROL Hydrochloride / *for Oral Use:*

Demerol hydrochloride tablets 50 mg.

Demerol hydrochloride tablets 100 mg.

Demerol hydrochloride elixir (50 mg. per 5 ml. teaspoon)—Pleasant banana flavor, nonalcoholic. Especially useful for children.

A.P.C. with Demerol tablets—For potentiated action each tablet contains: 200 mg. (3 grains) of aspirin, 150 mg. (2½ grains) of phenacetin, 30 mg. (½ grain) of caffeine, and 30 mg. (½ grain) of Demerol hydrochloride.

Subject to regulations of the Federal Bureau of Narcotics.

THE STANDARD **DEMEROL®**

for Controlled, Safe Analgesia in Obstetrics



Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

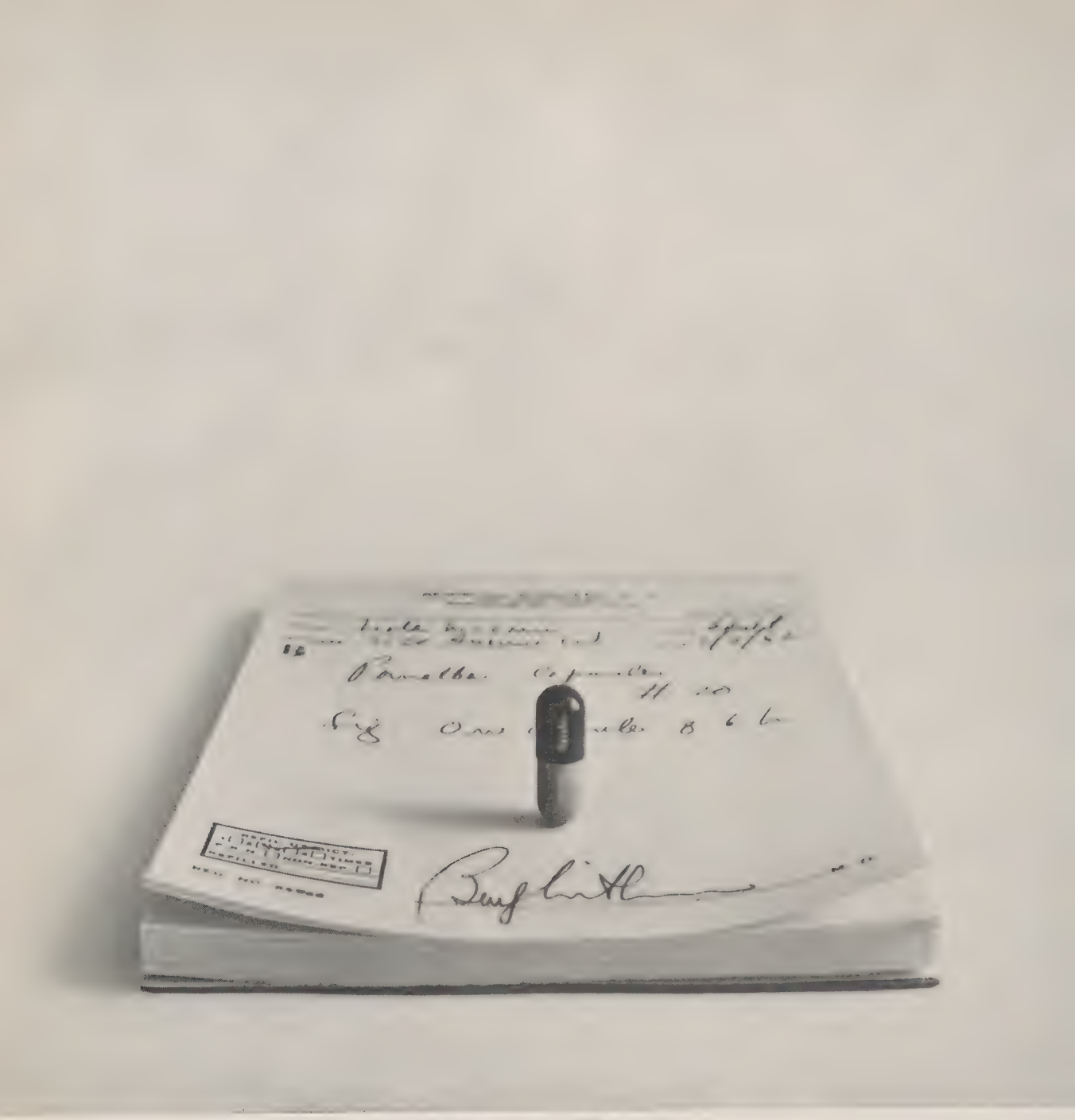
How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

When you suggest to your patients that they have a big glass of orange juice for breakfast, or for a snack, or when they want to raid the refrigerator, the deliciousness of Florida orange juice will give you assurance that they'll *want* to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

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Launching Pad

In infections of unknown etiology, prescribe Panalba. From the outset, pending laboratory determinations, your treatment is broadened in antibacterial coverage because of the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

Panalba combines tetracycline (selected for its breadth of coverage) and novobiocin (selected for its unique effectiveness against staph). That is why, in most infections of unknown etiology, Panalba offers excellent chances for therapeutic success— and why it should be your antibiotic of first resort.

Upjohn
The Upjohn Company
Kalamazoo, Michigan

Panalba* product information

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

Usual Adult Dosage: 1 or 2 capsules three or four times a day.

Side Effects: Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

*TRADEMARK, REG. U. S. PAT. OFF.

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DECEMBER, 1961

Digitalis

in its completeness



Each pill is
equivalent to
one USP Digitalis Unit

Physiologically Standardized
therefore always
dependable.

Clinical samples sent to physicians upon request.

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"The first prescription I ever wrote was for 'Empirin' with Codeine...



and it is still my stand-by for pain relief today."

PICTURE THE YOUNG DOCTOR with his first private patient, about thirty-five years ago. This is the moment, after years of study and guidance in classroom and at hospital bedside, when he assumes the full weight of responsibility for the well-being of his patient. He makes his diagnosis. The patient is in considerable pain, and his first concern is to relieve this discomfort. He writes a prescription for a new analgesic, a convenient drug combination that he believes will be of help. This patient (and many others to follow) finds gratifying relief, and the physician continues to rely upon this medication as the years go by.

Could this have been you in the 1920's? That was when 'Empirin' Compound with Codeine first came into general use (although plain 'Empirin' Compound has been well-known since the influenza epidemic of 1918). Satisfaction through the years has prompted doctors everywhere to depend on 'Empirin' with Codeine for relief of most all degrees of pain. For with this well-tolerated, reliable analgesic combination you can be sure of results, and feel secure in the fact that the liability of addiction is negligible.

Please accept our thanks for continuing to place your trust in a product that has been used more widely in medicine each year for the past four decades.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE*

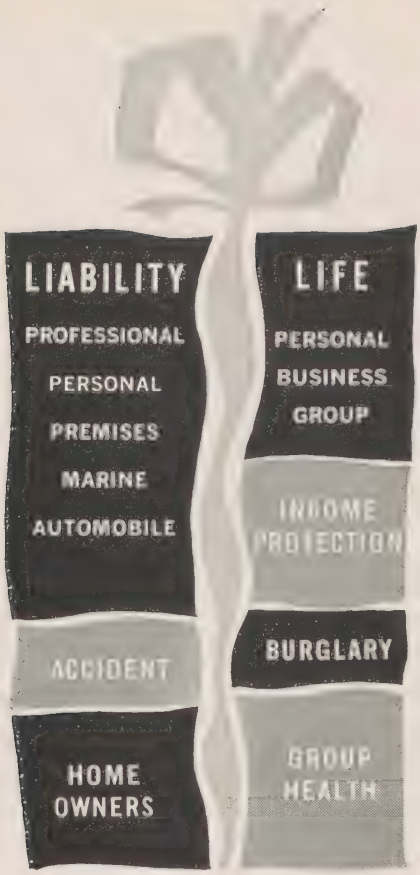
Acetophenetidin, gr. 2½
Acetylsalicylic Acid, gr. 3½
Caffeine, gr. ½

Remember there are now four strengths available...

**Warning—May be habit-forming.*
Subject to Federal Narcotic Regulations.

No. 1 – gr. ⅛
No. 2 – gr. ¼
No. 3 – gr. ½
No. 4 – gr. 1

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A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

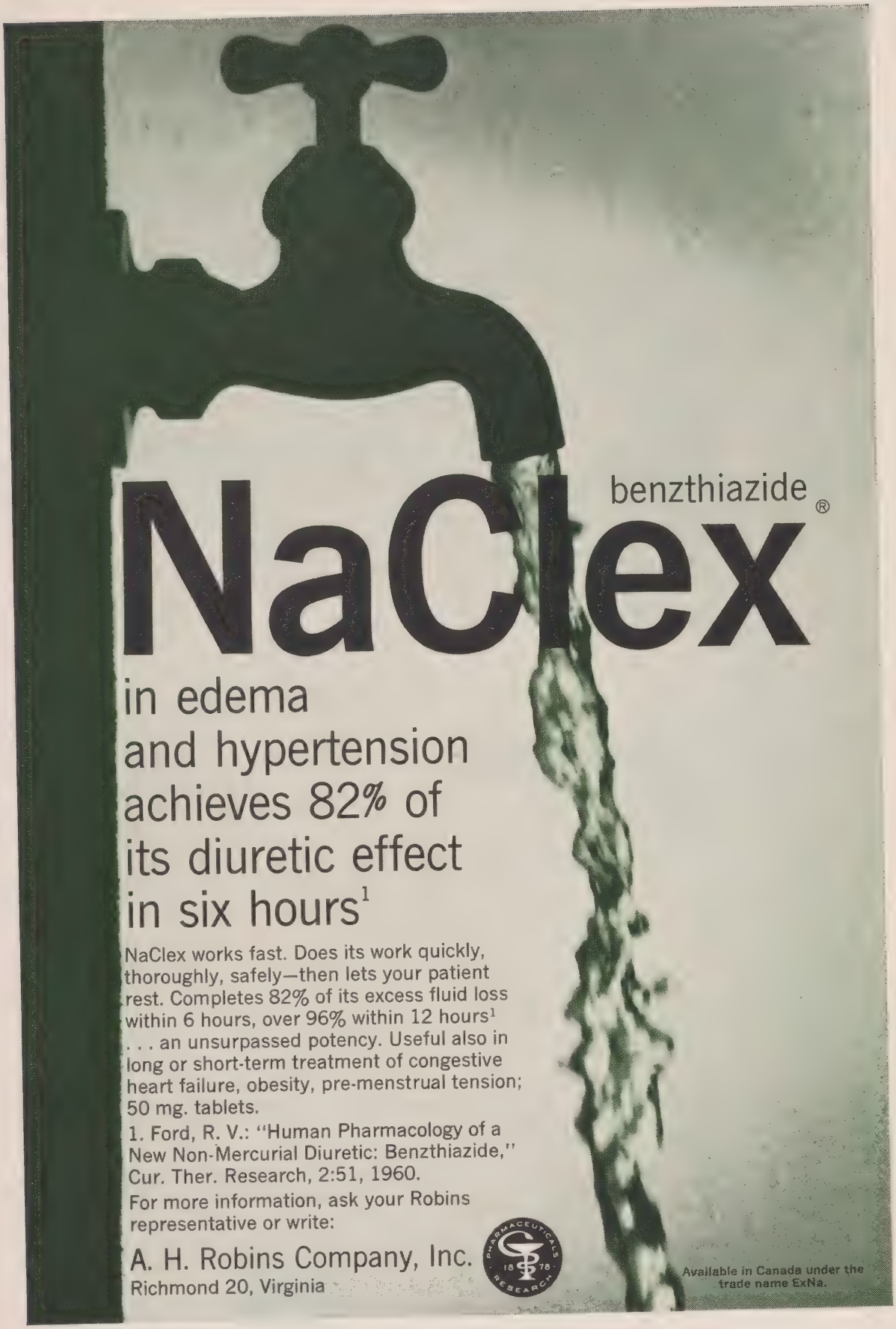
The Hospital is located in a 75-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

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NaClex
in edema
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achieves 82% of
its diuretic effect
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NaClex works fast. Does its work quickly, thoroughly, safely—then lets your patient rest. Completes 82% of its excess fluid loss within 6 hours, over 96% within 12 hours[1] . . . an unsurpassed potency. Useful also in long or short-term treatment of congestive heart failure, obesity, pre-menstrual tension; 50 mg. tablets.
1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
For more information, ask your Robins representative or write:
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RELIEVE PAIN AND FEVER OF COLDS GRIPPE SINUSITIS INFLUENZA



HASAMAL®

(Analgesic-Antipyretic-Sedative)

- **Relieves pain and tension**
- **Reduces fever**
- **Stops excessive nasal secretions**
- **Without unwanted diaphoresis**

Hasamal, with mild sedation, effectively relieves malaise and discomfort associated with acute infectious disease, such as colds, grippe, sinusitis, tonsillitis, and for earache, headache, and pain of arthritis, neuritis, neuralgia, dysmenorrhea, etc.

Where pain of increased intensity occurs, HASACODE, containing ¼ gr. codeine phosphate, and HASACODE "STRONG," containing ½ gr. codeine phosphate, provide prompt, effective relief.

Composition: HASAMAL: Each tablet or capsule contains: Acetylsalicylic acid, 2½ gr., acetophenetidin, 2½ gr., phenobarbital, ¼ gr., and hyoscyamus alkaloids, .0337 mg. HASACODE combines the same formula as Hasamal with ¼ gr. codeine phosphate, and HASACODE "STRONG" ½ gr. codeine phosphate.

Dosage: Hasamal: One or two tablets or capsules every 3 to 4 hours. **Hasacode:** One or two tablets every 3 or 4 hours; not more than 8 tablets should be taken in 24 hours. **Warning:** Do not use in patients with glaucoma or in elderly patients with prostatic hypertrophy.

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Richmond, Virginia

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in the convenience
of intramuscular
antibiotic therapy

Terramycin®
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oxytetracycline for intramuscular injection, ready to use in sterile syringe with sharp, sterile needle — all in one integrated, entirely disposable unit

completely sealed to prevent syringe-transmitted hepatitis/ ready-to-use/tamper-proof/ disposable...and surprisingly economical

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provides the benefits of Terramycin Intramuscular Solution: rapid effectiveness against a broad range of pathogens; rapid, wide distribution in body tissues and fluids; excellent toleration

plus . . . all the advantages of the ISOJECT unit:

convenient completely self-contained/no intricate assembly/no chance of lost parts

sterile and completely disposable prevents syringe-transmitted hepatitis

economical compares very favorably in cost with less convenient and practical forms — and reduces likelihood of breakage and waste

tamper-proof unit is safely sealed

presently available ISOJECT forms:
Terramycin® Intramuscular Solution — 100 and 250 mg.
Vistaril® Parenteral Solution — 25 and 50 mg.
Streptomycin Sulfate Solution — 1 Gm.

IN BRIEF

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. As with all I.M. preparations, injection should be made within the body of a relatively large muscle. Care should always be taken to avoid injection into a major nerve or its surrounding sheath. For complete dosage, administration, and precaution information, read package insert before using. Terramycin Intramuscular Solution contains 2% (W/V) Xylocaine.*

More detailed professional information available on request.

*Xylocaine® is the registered trademark of Astra Pharmaceutical Products, Inc., for its brand of lidocaine.

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CONTINUOUS

PROTECTION IN

ANGINA PECTORIS

ANTORA...

PROVIDES 10 - 12 HOURS GRADUAL RELEASE . . .

Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate . . . a clinically proven dosage form. For assured 24 hour control, administer one Antora capsule before breakfast and one before evening meal. ANTORA REDUCES NITROGLYCERIN REQUIREMENTS . . . IMPROVES EKG TRACINGS . . . PROVIDES BETTER EXERCISE TOLERANCE . . . REDUCES NUMBER AND SEVERITY OF ATTACKS. Administer with caution in glaucoma.

FOR THE UNDULY APPREHENSIVE PATIENT . . .

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REFER TO PDR

PAGE 643

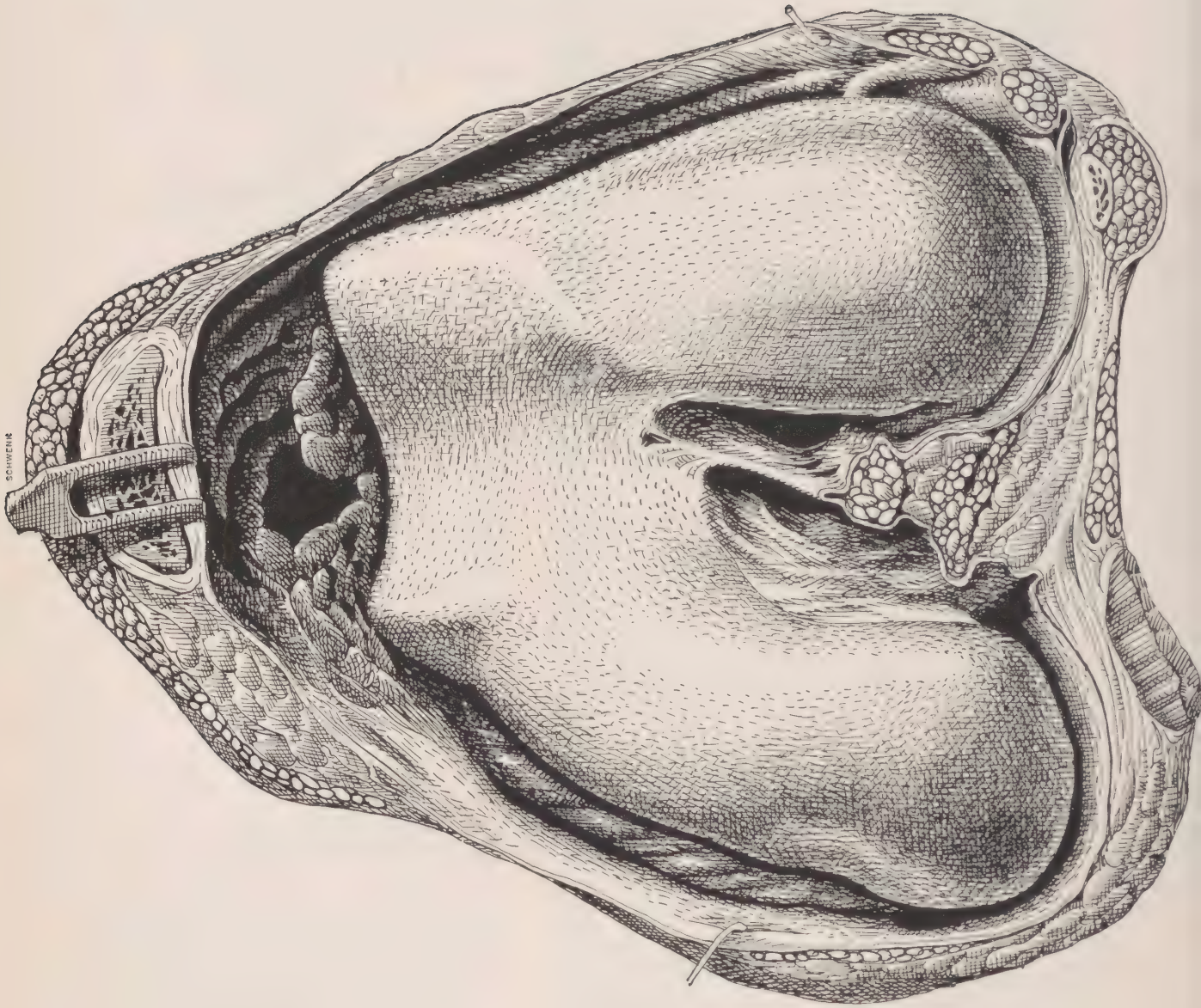
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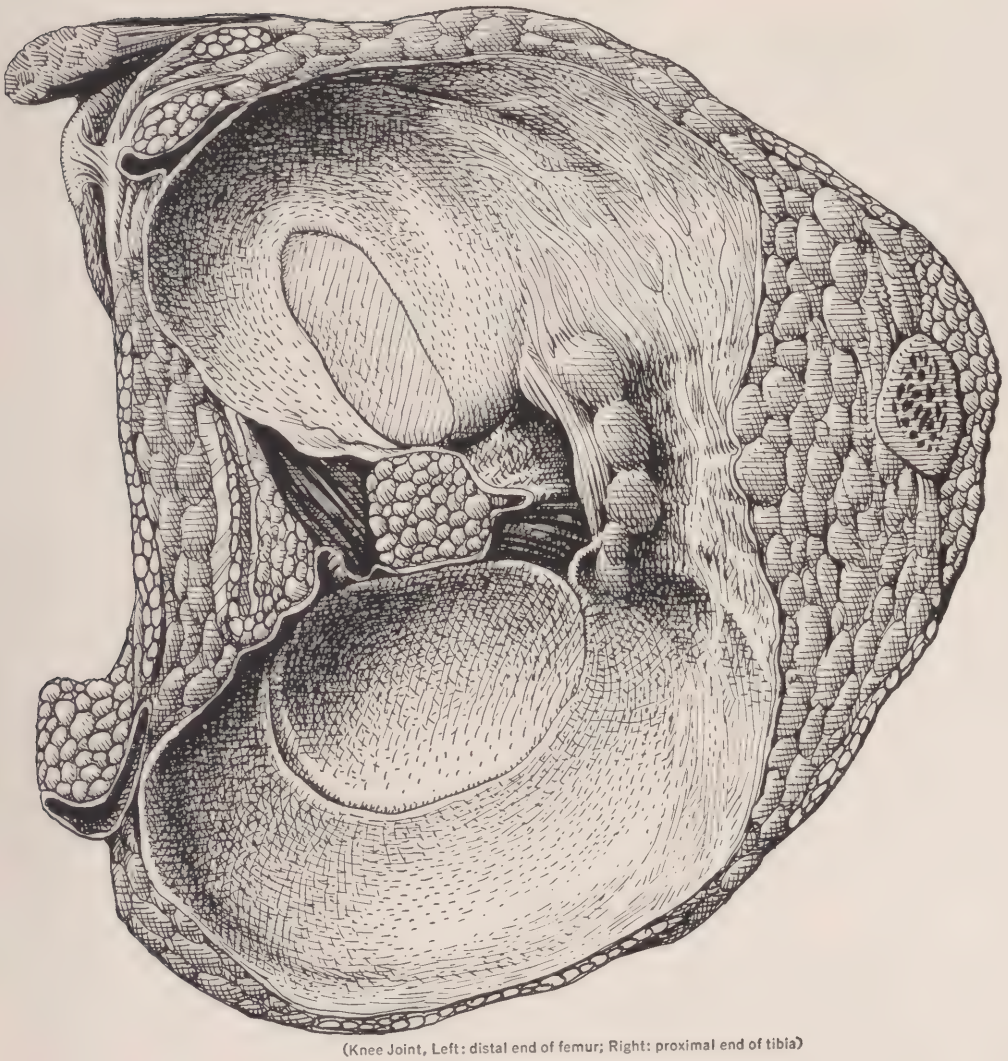
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Unsurpassed "General Purpose" and "Special Purpose" Corticosteroid...
Outstanding for Short- and Long-term Therapy

Aristocort®

Triamcinolone Lederle



(Knee Joint, Left: distal end of femur; Right: proximal end of tibia)

ARISTOCORT is an outstanding "special purpose" steroid when the complicating problem is increased appetite and weight gain, sodium retention and edema, cardiac disease, hypertension or emotional disturbance and insomnia.

ARISTOCORT provides unsurpassed anti-inflammatory control without sodium retention or edema — without the undesirable psychic stimulation and voracious appetite.

Supplied: Scored tablets (three strengths), syrup, parenteral and various topical forms. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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FOR MEMBERS OF
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For total disability from accident:
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MONTHLY BENEFIT first
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for loss of both hands, feet, eyes; one hand and one foot; either hand or foot and one eye.
Loss of either hand or foot, monthly benefit for 20 months ----------$ 300.00
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(and in addition, the monthly and hospital benefit for the period between date of accident and date of death)

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$100.00 ADDITIONAL MONTHLY BENEFIT FOR TOTAL DISABILITY for as long as one year is available by rider.

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Disability Benefits begin with first day of disability and medical attention.
Pays total disability income benefits for life—covering both accidents and sickness.
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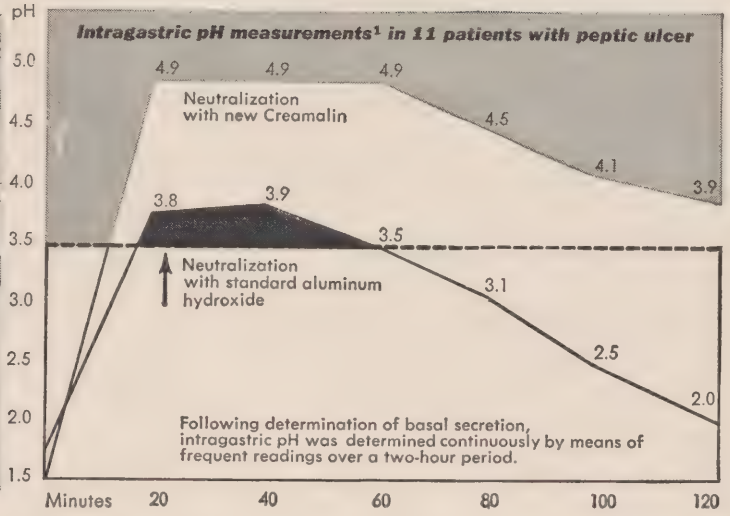
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3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

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infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

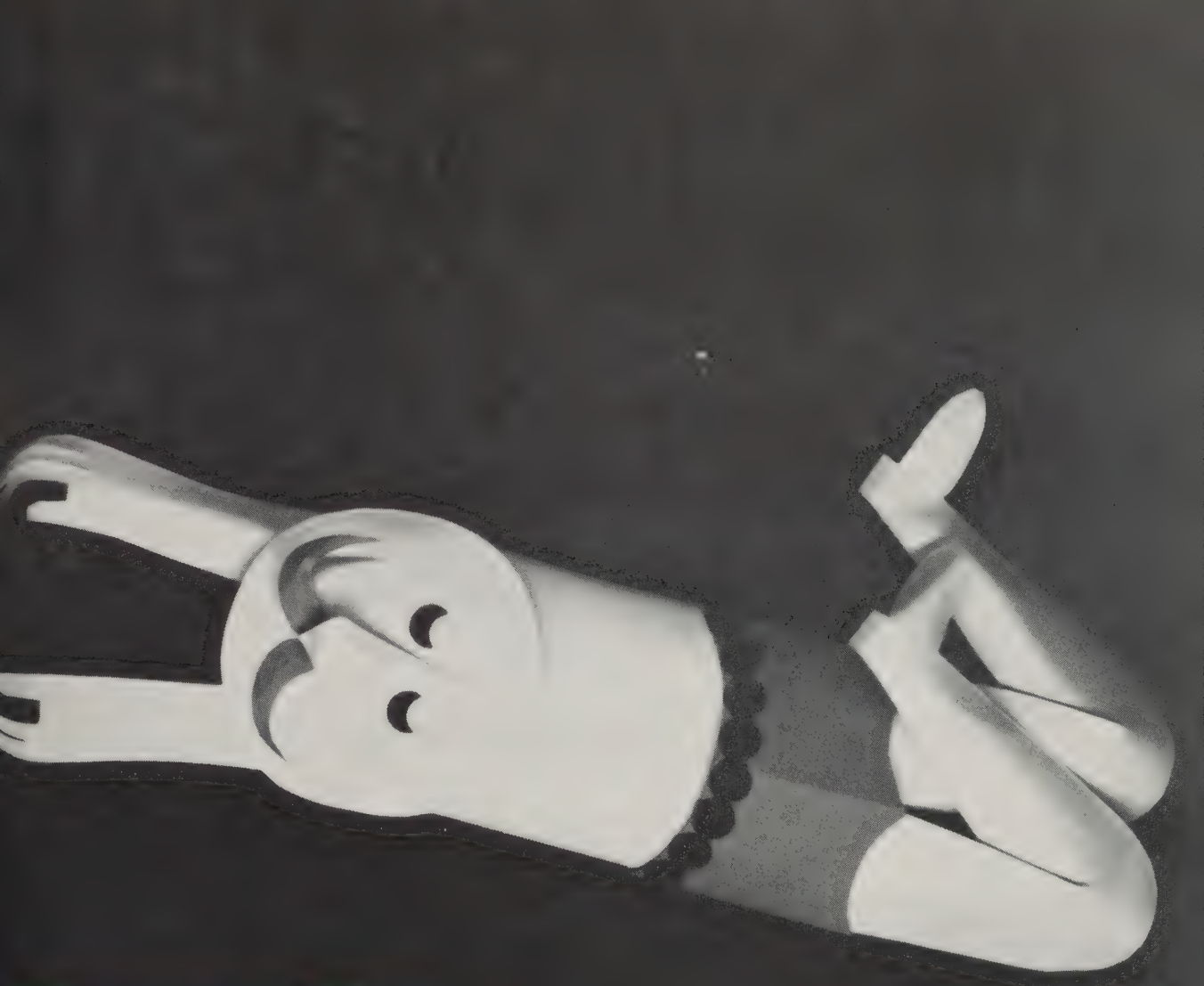
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8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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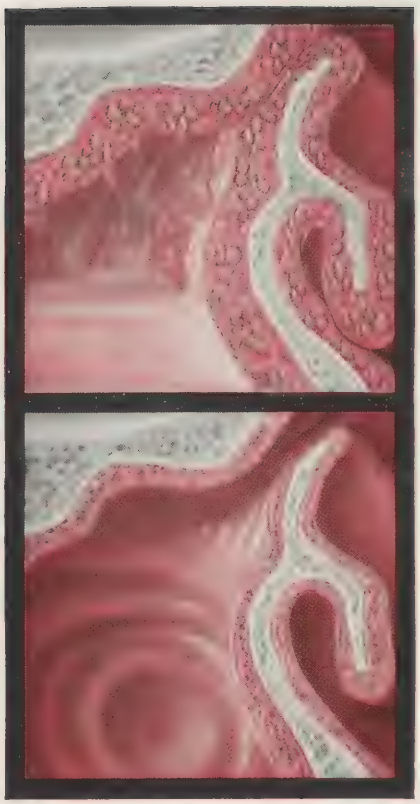
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. **2.** Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. **3.** Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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ORIGINAL ARTICLES

Biochemical Relationships in Allergic Disease—*Kelly T. McKee, M. D.* ---- 115

Medical School Relationship To Its Community—The Case for the Community Hospital—*William H. Prioleau, M. D.* ---- 122

EDITORIALS

Annual Meeting Next Month ---- 128

Care of Contact Lenses ---- 128

Papers Invited ---- 128

Syphilis in South Carolina ---- 128

Who Runs the Association? ---- 129

On Presenting Papers ---- 130

FEATURES

President's Page ---- 127

General Program, S.C.M.A. 114th Annual Meeting ---- 131

Scientific Program, S.C.M.A. 114th Annual Meeting ---- 133

Committee Reports ---- 138

Exhibitors' Pages ---- 159

Deaths ---- 161

Public Relations ---- 162

News ---- 164

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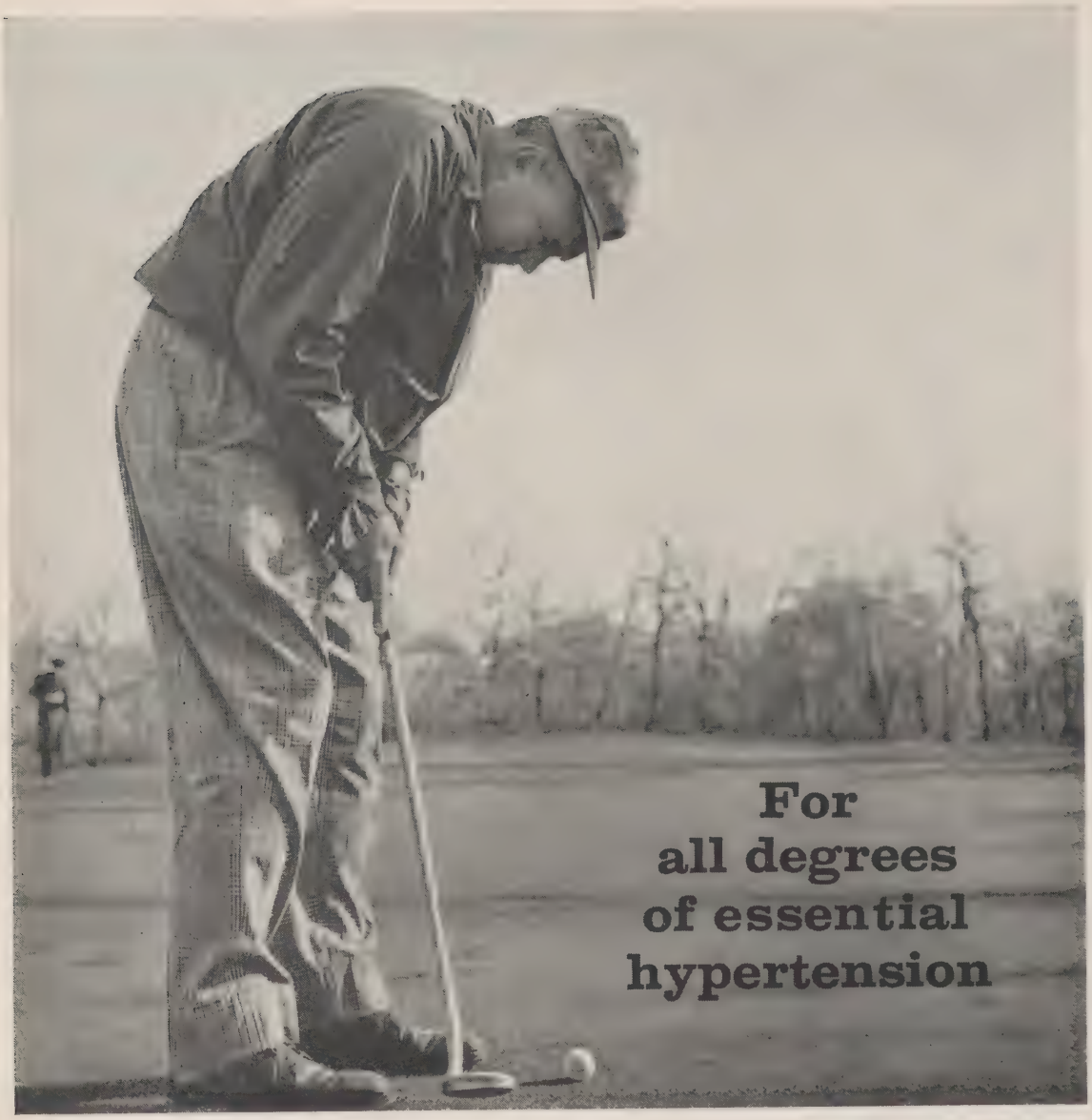
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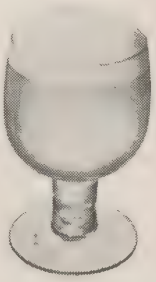
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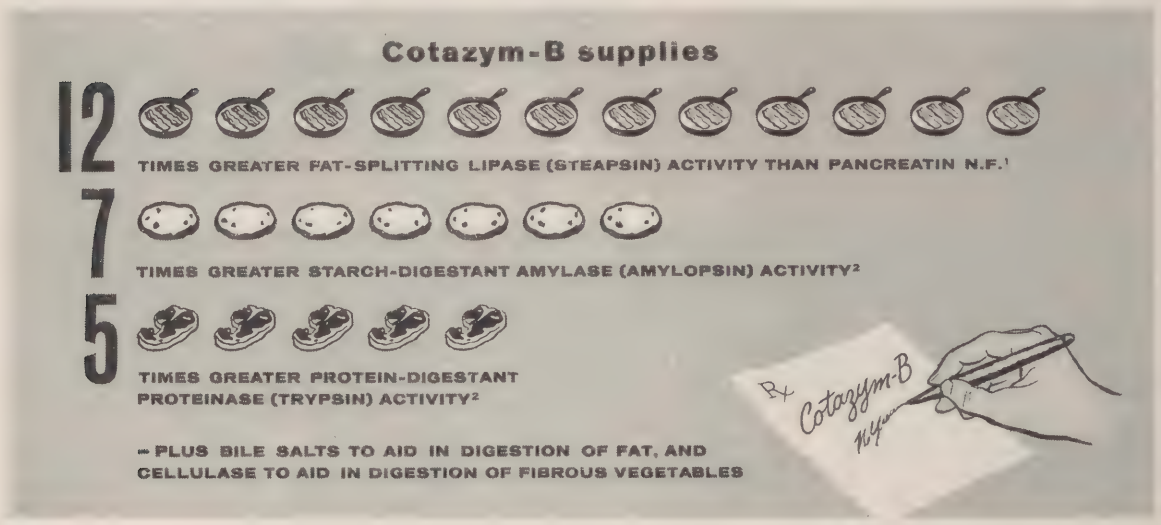
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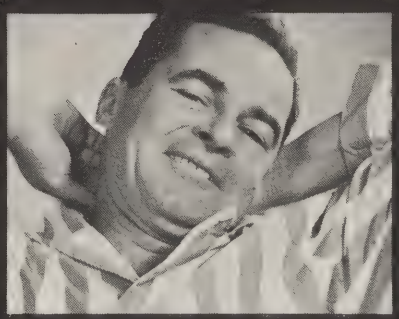
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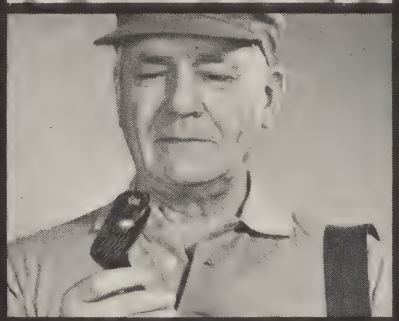
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BIOCHEMICAL RELATIONSHIPS IN ALLERGIC DISEASE

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Allergic disorders constitute a significant proportion of illness with which physicians deal in daily practice. Mechanisms involved in the occurrence of the allergic reaction continue to stimulate much research. Histamine for years, and a number of other substances more recently, have been implicated as chemical mediators, and a large volume of literature has accumulated relating to their participation in the development of the end product of antigen-antibody combination. This presentation is a summary of some of the pertinent information.

Present day treatment of bronchial asthma employs measures which are designed to eliminate exposure to allergens, to desensitize to allergens which are unavoidable and to control symptoms with a variety of drugs which are known to relieve the disorder symptomatically. Preparations in this latter group include sympathomimetic drugs and other bronchodilator agents, parasympatholytic drugs, agents which change bronchial secretions, sedatives, and medications such as steroids which are effective but whose basic mechanism of action is not well defined.

In the pathologic physiology of asthma, bronchial and bronchiolar spasm, mucosal edema, and increased bronchial secretions are recognized to play a part. Recognizing that the response to the antigen-antibody reaction is a fundamental determinant in the pathogenesis of the disorder it becomes apparent that knowledge of the pharmacology and biochemistry of this reaction and the pharmacologic effects of the reaction is essential for further advance in the treatment of the condition.

In the past fifty years a number of substances have been identified or suspected to be produced or released as a result of the antigen-antibody reaction. Among these are histamine, acetylcholine, heparin, serotin, bradykinin, and slowly-reacting-substance-A.

From the time of the first observations on the occurrence of anaphylactic shock explanations of the phenomena of anaphylaxis have been theorized. One of the earliest of these was that of Friedberger who, in 1909, observed that a precipitate formed by antigen-antibody combination, incubated with normal serum yielded a substance that caused shock in guinea pigs.[1] He concluded that this shock was similar to anaphylactic shock and called the substance "anaphylotoxin". Others subsequently observed that a similar "toxic" principle could be produced by incubating agar,

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starch, kaolin, and other substances with serum, thus lessening the specificity of the production of anaphylotoxin.[2] This "humoral" theory of anaphylaxis and the anaphylotoxin concept was largely abandoned after observations of Dale and co-workers that as a result of a direct "cellular" reaction—the contact of antigen with sensitized cells—histamine, or a histamine-like substance, was produced.[3] Since the first observations of Dale regarding the release of histamine-like substance, many studies tending to support the histamine-release theory have been reported, and in recent years a variety of other chemical substances or mediators has been identified or suggested as important factors in the development of the end product of the antigen-antibody reaction. Histamine having been the first of these found and the most likely, has received most study.

Histamine

Histamine, beta imidazolyl ethylamine was first obtained by Windaus and Vogt in 1907 by decarboxylation of histidine.[4] In 1910 Barger and Dale isolated it from ergot.[5] The similarity of response after histamine injection to anaphylaxis led them to suggest that it might be the agent responsible for the reaction in anaphylaxis.[6] This chemical is widely distributed in the body and varies from organ to organ in concentration. The content in various organs varies widely in different animal species.[7] The actual origin in the tissues was unknown until Riley in 1953 reported observations supporting his hypothesis that the mast cell or basophil was its source.[8] It had been observed several years earlier by Jorpes that mast cells contained heparin.[9] The report of McIntosh and Paton in 1949 on histamine liberators apparently stimulated Riley's observations.[10] He noted that stilbamidine, a histamine liberator, fluorescent under ultra-violet, could be shown after injection to be present in small accumulations along blood vessels. Such accumulations took the basic dye characteristic of the metachromasia of mast cells, and mast cells studied under such circumstances could be shown to be disintegrating.[8] Such tissues analyzed for histamine content could be shown to be losing histamine under these circumstances. Riley also observed that tissues containing no mast cells contained no histamine (rat liver being an example) and tissues with high mast cell content had high histamine values. He also noted that in beef lung mast cells were large and numerous under the pleura and that histamine was concentrated where mast cells were situated. Mast cell tumors have been shown to contain a high content of histamine.[11] Such observations strongly suggest that most of the body's histamine resides in the mast cell. Its release from these cells can be accomplished in a variety of ways. Many substances have been found to have histamine-releasing activity.

Histamine-releasing agents include:[12]

1. Sensitizing compounds.
2. Tissue damaging compounds such as venoms, toxins, traumatic agents.
3. Proteolytic enzymes such as trypsin.
4. Surface active agents such as Tween-20 and bile salts.
5. Large molecules such as egg white, dextran, polyvinyl-pyrrolidine, horse serum, anaphylotoxin.
6. Histamine liberators such as compound 48/80, stilbamidine, etc.
7. Monobasic compounds such as the alkylamines.

The mode of action of histamine-releasing agents is not entirely clear. It has been suggested that the basic histamine liberators have an affinity for heparin, which is known to have its origin in mast cells, and as a result of the heparin-histamine-liberator complex, membrane permeability for histamine increases, liberating it from the mast cell granules.[13]

The mechanism by which histamine release by histamine-liberators occurs appears different from the mechanism of release in anaphylaxis. It has been shown that histamine release in anaphylaxis is an energy-requiring process blocked by oxygen lack, iodoacetate, cyanide, and other metabolic inhibitors. The histamine-releasing effect of compound 48/80 and of octylamine does not require energy and is potentiated by oxygen lack and by iodoacetate.[14] This and other observations suggest that histamine release in anaphylaxis is an

enzymatic reaction. In observations on the effects of histamine releasers and anaphylaxis on intracellular histamine-containing particles it has been found that releasers work whether used in intact or minced tissues or cell-free homogenates. Release of histamine in anaphylaxis however, requires intact cells and does not occur in cell-free homogenates.[15] Antihistamines block the effect of administered histamine and of releasers but do not have the same blocking effect in anaphylaxis.

The first conclusive evidence of release of histamine in the antigen-antibody reaction was presented in 1932 by Bartosch and co-workers by perfusing isolated lungs of a sensitized guinea pig with Ringer's solution and adding antigen to the perfusate.[16] The substance in the effluent was pharmacologically identical with histamine in its actions. Schild in 1951 demonstrated the release of histamine from human asthmatic lung.[17] He and his co-workers demonstrated that the addition of specific antigen to a bath containing human asthmatic bronchial rings caused strong contraction of the bronchial muscle; that the same substance added again did not produce contraction but that another antigen to which the patient was sensitive did do so and that the desensitized muscle still responded to histamine and to acetylcholine. It is of interest that in a similar experiment the effect of added histamine can be promptly counteracted by the addition of an antihistamine but the effects of the added specific antigen are quite resistant to the antihistamines. Anti-histamine drugs are said to be ten thousand times more effective to added histamine than against antigens.[15] This suggests of course participation of agents other than histamine alone in the tissue response to antigen.

From a study of histamine release from guinea pig slices by antigen-antibody reaction, Mongar and Schild in 1957 suggested that the antigen-antibody reaction activated an enzyme present in tissues in an inactive form and in this way brought about the release of histamine.[14] Since the late 1940s anaphylotoxin has again been suspected by many to be the major factor in histamine release during *in vivo* anaphylaxis. More recent studies however point out that the point of attack of anaphylotoxin upon sensitized cells is not the same as that involved in reactions following contact with specific antigen.[18] An increased proteolytic activity in serum following antigen-antibody combination is well known. It has been observed that after injection of antigen there is an association between an increase in proteolytic enzyme activity, a decrease in proteolytic enzyme-inhibitor activity and the presence of anaphylactic shock. In addition a close correlation between the increase in proteolytic activity of isolated guinea pig tissue and histamine release has been observed.[19] Whether proteolytic enzymes are actually involved in the histamine-release reaction is still uncertain, however.

Certain objections to the histamine release theory as a cause of anaphylaxis of course have been voiced for a long period.[20] These include: The amount of measurable histamine released in anaphylaxis is much smaller than the amount that must be injected to produce a reaction. In some situations histamine is actually inactive and does not produce the effects seen in anaphylaxis. Isolated rat uterus, for example, relaxes with histamine. Histamine-desensitized guinea pig uterus gives a maximum response to the antigenic substance. Anti-histamines are generally ineffective in preventing many anaphylactic reactions. Histaminase, the enzyme which destroys histamine, has been unsuccessful as a therapeutic agent in allergy.

Quantitative determination of blood and plasma histamine has added additional information relating to the importance of histamine in anaphylaxis. It has been observed that in some species during animal anaphylaxis a moderate rise in plasma histamine and a depletion in cellular histamine occurs.[23] Katz and Cohen[25] and other investigators since them, have demonstrated the *in vitro* release of histamine from sensitized leucocytes on exposure to antigen. Noah noted that blood from "atopic" individuals only showed this histamine release phenomenon, that compound 48/80 did not cause histamine release in humans, and that *in vitro* release of histamine

from atopic individuals with specific antigen added may be increased with addition of 17-hydroxy-steroids.[26] In human beings histamine blood levels have been said to rise three times above normal in whole blood during acute asthma.[21] More recent studies have not supported these findings though levels have been observed to fluctuate widely as compared to normal.[22] Studies by Van Arsdale and associates have shown a consistent elevation in venous plasma levels during active asthma.[27]

The possibility of the relationship of histamine release to exercise as a factor in asthmatics[28] and of histamine release after morphine as a factor in asthma[29] has been mentioned though not adequately evaluated.

Acetyl Choline

Though much experimental evidence suggesting that histamine is released in anaphylaxis has accumulated, many doubts as to its importance in clinical allergic states have been voiced. Among other suggested agents has been acetyl choline. Wenner and Buhrmester found that potassium and a substance resembling acetyl choline were released into the blood after shocking doses of antigen were given sensitized rabbits.[30] It has been noted that anaphylactic shock is independent of direct action of nerves, but the effects on the respiratory tract of guinea pigs by acetyl choline, vagal nerve stimulation, and anaphylactic shock appear similar—broncho constriction develops in all three.[31] One Japanese investigator has observed that his experimental evidence supports the view that acetyl choline is far more important in mediating the anaphylactic reaction than is histamine.[32] It has been suggested that emotionally induced asthma and urticaria is produced by acetyl choline causing histamine release.[33]

Heparin

An early objection to histamine as cause of anaphylaxis was incoagulability of blood observed by Arthus in 1915[34] and Biedl and Kraus[35] in 1908 in anaphylaxis in the dog. Howell in 1925 suggested that the release of heparin from the liver was responsible for this.[36] This was proven by Jaques and Waters.[37] In 1938 Wilander was able to show that mast cells (tissue basophils) released heparin in anaphylactic shock in the dog.[38] Liberation of histamine in anaphylaxis in the dog has been observed to parallel that of heparin. Heparin is observed to be retained longer being much less diffusable.[39] Jorpes in 1946 reported the heparin content of a variety of tissues noting the parallelism between mast cell content and heparin in such tissues.[9]

Though in anaphylactic reactions in a variety of animal species a sulfated mucopolysaccharide is apparently produced, only in the dog has it been demonstrated that incoagulability of the blood is a manifestation of anaphylaxis and apparently heparin as such is not produced in most animal species.[40]

SRS-A

The term *slowly reacting substance* was first used by Feldberg and Kellaway[41] to describe an unknown smooth-muscle-stimulating substance which appeared in the perfusate from guinea pig lung after injection of cobra venom. Slow reacting substances are formed after induction of injury by venoms, bacterial toxins, peptone and trypsin. A typical response is a slowly proceeding contraction of isolated guinea pig ileum followed by slow relaxation after fluid bath is changed. Two entirely different groups of SRS have been established. One consists of polypeptides, the other of lipid-soluble acids. Bradykinin is in the group of polypeptides. It is formed when trypsin acts upon serum globulin. It is also formed by the action of other proteolytic enzymes. Bradykinin-like substances appear during anaphylactic shock in dogs or during antigen antibody reaction in isolated guinea pig ileum.

It was observed in 1940 by Kellaway and Trethewie that after anaphylactic shock there appeared in the venous effluent of the lungs not only histamine but also another substance with smooth muscle-stimulating properties. On isolated guinea pig ileum the effluent caused contraction more prolonged than that produced by pure histamine and after the bath fluid was changed the ileum relaxed more slowly, different from histamine.[42]

Brocklehurst[43] investigated the properties of the slowly contracting principle which he

called SRS-A (slow reacting substance—anaphylaxis) and noted that the action was not due to 5-hydroxytryptamine, bradykinin or histamine. Unlike 5-hydroxytryptamine it contracted isolated human bronchioles, and unlike bradykinin it was not destroyed by proteolytic enzymes. Its action persisted in the presence of mepyramine, suggesting that it was not histamine. He succeeded in separating SRS-A from accompanying histamine by collecting the effluent from perfused sensitized guinea pig lungs after injection of antigen and passing it over activated charcoal, which absorbed SRS-A. This was eluted with 8% butanol in water. With samples so prepared he showed that SRS-A produces a slowly proceeding contraction of guinea pig ileum followed by delayed relaxation after the bath was changed. Contractions produced subsequently by histamine were potentiated and the sensitivity of the gut slowly returned to normal.

SRS-A contracts isolated rat duodenum, human bronchioli, has no effect on rat colon, guinea pig, or rat uterus, or bronchioli of cat, dog, rabbit or guinea pig in doses 20 times as great as those effective on guinea pig ileum. It was not detected in perfusates or extracts from sensitized lungs without contact with antigen. After injection of antigen it could be extracted from disintegrated lung tissue by 70% alcohol. SRS-A also appears in the effluent from human asthmatic lung perfused with allergen solution. SRS-A seems to be an acidic solution with certain lipid solubility. It appears likely that it may play a part in the bronchospasm of human bronchial asthma.

Serotonin

The importance of another substance, serotonin, 5-hydroxytryptamine, in allergic disease was suggested when it was found that carcinoid syndrome, in which attacks of bronchospasm are seen, is due to the production by the carcinoid tumor of 5-hydroxytryptamine.[44] Investigations have subsequently shown that this chemical is in fact liberated in antigen-antibody reactions in some carcinoids.[45] In 1955 Humphrey and Jaques noted the release of serotonin and histamine from platelets after addition of antigen and antibody to platelet suspensions in plasma[46] Waalkes in 1957 demonstrated the presence in plasma of serotonin and histamine after injection of specific antigen into sensitized rabbits.[47] Rabbit platelets have been found to be rich in serotonin.[48]

Platelets disappear from the circulation in anaphylaxis—apparently trapped in the tissues. Their disappearance from circulation in man has been observed in hypersensitivity reactions.[49] In rabbits serotonin and histamine in the lung increase along with a fall in circulating platelets.[50] In some species the lungs contain relatively large amounts of serotonin; the human lung, however, contains very little.[51]

Berg found an increase in the serotonin breakdown product, 5-hydroxyindoleacetic acid in the urine in asthmatic patients.[52] This observation has not been verified.

Serotonin content in the skin of the rat and mouse is high but is very low in other species. In these species serotonin is found in the mast cells.[53] Human mast cells contain essentially no serotonin.[53] Mast cell tumors have not been found to release serotonin in anaphylaxis even in rodents.[54]

Anaphylaxis is said to be better explained in the mouse by serotonin release. Lysergic acid diethylamide and reserpine both inhibit the ability of antigen to cause contraction of sensitized mouse uterus, using the Schultz-Dale technique. Serotonin is a potent uterine contracting agent in this situation. Histamine has little effect.[55]

It would appear from this brief summary of observations regarding serotonin that while it may play a part in anaphylaxis in some animal species, little support for its participation in allergic reactions in humans exists.

Conclusion

In conclusion, though a voluminous literature relating to mechanisms involved in the biochemistry of the allergic reaction has accumulated, of which the references here constitute only a small fraction, much is yet to be explained. While the participation of histamine appears fairly well documented, the remaining substances discussed still occupy a very

uncertain position, and much additional research on the subject can be expected in the future.

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Review of 50 patients with fissure in ano. C. W. Graham-Stewart, R. K. Greenwood, and R. W. Lloyd-Davies. Surg Gynec Obstet—113:445 (Oct.) 1961.

Acute fissure in ano is a common condition which causes distressingly severe symptoms. Treatment varies. In this series of 50 consecutive patients seen in the rectal clinic of a general hospital, the policy of stretching the sphincter under general anesthesia in outpatients has been adopted in patients complaining of severe symptoms and in the majority of those with moderate pain. The patients with mild symptoms have been treated with 1% dibucaine (Nupercaine) suppositories. The authors found that stretching the sphincter is an effective treatment for fissure in ano. They would like to know how their results compare with those achieved with other forms of treatment. Widening of the pecten ring is considered more important than the relief of spasm in acute fissures. A reason is given for the posterior position of the great majority of fissures in ano.

Effective control of staphylococci in a nursery. H. J. Simon, S. J. Yaffe, and L. Gluck. New Engl J Med—265:1171 (Dec. 14) 1961.

Staphylococcal colonization was successfully prevented in a newborn nursery. Application of pHisoHex in the delivery room and once daily thereafter resulted in an overall colonization rate of 1.3% among 777 infants sampled at four body sites. Nasal colonization was eliminated without the use of intranasal medication. No attempts were made to control staphylococcal carriage among personnel or mothers. Only 4 instances of mild staphylococcal infection occurred among 547 infants followed carefully for 6 months. Three additional cases of mild infection were reported from the remainder of the 5,965 infants born during the period of the study. One instance of maternal staphylococcal mastitis was also reported. Almost all of these infections seemed to have been acquired at home. Prevention of colonization in the hospital seems to minimize neonatal and maternal staphylococcal disease. Untoward reactions to pHisoHex were minimal.

MEDICAL SCHOOL RELATIONSHIP TO ITS COMMUNITY*

THE CASE FOR THE COMMUNITY HOSPITAL

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According to the by-laws, in case of death of the president, the first vice-president shall preside, and the presiding officer shall give the presidential address. I have selected a subject which has engaged my time and effort for many years. It is the *Medical School Relationship To Its Community.* My interest in this subject has been prompted by our local situation, however, the thoughts expressed in this paper are based also upon personal observations and inquiries in other medical centers, upon data acquired during hospital inspections for appraisal of residency programs, and upon articles in state and national journals. While the problem manifests itself differently in various localities, depending particularly upon population and wealth concentration, the most important common denominator is the economic aspect. The subject will be presented upon a basis of principles applicable to those communities in which the hospital economy is materially affected by the presence of a medical school. Members of this association, being familiar with these problems, can contribute a great deal toward a reasonable solution. This would be an important step in the next great advance in medical education which logically should be through the community hospitals.

Paradoxical as it may seem, the proximity of a medical school to a community hospital may affect adversely the scope and standards of hospital service generally available to the community. In such a situation there may arise on the institutional level problems of an economic and political nature in the competitive areas of hospital administration, and in patient domain in both private and indigent categories. For the individual physician the situation is conducive to problems of professional prerogatives, responsibilities, and competition. A working agreement based upon recognition by the medical school that the community must have adequate hospital facilities of its own, and an understanding by the local profession of the requirements of a present day day medical school, would remove the major causes of controversy and there would remain no real obstacle to a mutually advantageous relationship at an institutional level. Remaining personal differences would be of relatively minor importance.

Any consideration of medical school—community relationship must concern itself primarily with relations between the local profession, which naturally assumes professional responsibility for the medical welfare of the community, and the full-time faculty of the school acting as a group as well as individually. Differences between the two groups arise most commonly as the result of differing viewpoints towards the *economic ideology of subsidy in the cause of education,* under which the medical school, as an institution, and its full-time staff practice in both the indigent and the private patient categories. While the local profession subscribes to this ideology as the only means of financing the high cost of medical education, it is critical of those local applications which interfere with the maintenance of high standards of professional care in the community hospital. Problems arising from this source are most likely to occur in areas of low population concentration, but they may exist

*Presidential address. Southern Surgical Association, Hot Springs, Virginia, December 5, 1961.

also in larger cities where economic and political factors prevent community hospitals from obtaining public welfare and fund-supported patients sufficient to maintain a well-rounded residency program. Particularly prone to such problems is the situation in which a medical school, which has long served the community in the community hospital, erects a hospital of its own and institutes the full-time system in its clinical departments. Fortunately, to the credit of the medical profession, it can be safely said that any personal differences are more than compensated by professional interests and ideals held in common by the individual members of the two groups. Resentment of any real significance is upon an institutional level.

Members of the local medical profession fully understand the advantages to the school of having the full-time staff enjoy the prestige of school position, certain financial advantages, relative freedom from office routines, and protection from certain types of patient interruptions in order that ample time for teaching and research be insured. The local profession is even reasonably tolerant of the occasional unrestrained press releases of the public relations department of some medical schools. Adherence to the referral system is recognized as a sincere effort by the school to control the type and amount of private practice by its full-time staff, and at the same time, offer some degree of economic protection to the local profession. While abuses of the referral system occur, they are not sufficiently frequent to be a matter of great concern. Probably the most common type of abuse is that of some physicians to refer patients for personal considerations and hospital expense advantages, and not primarily for medical reasons.

Members of the full-time staff, with few exceptions, have had their education and training under the full-time system, and take little, if any interest in the professional and economic problems of the community hospital. They are primarily interested in the school and their own professional affairs; they accept the economic and practice policy of their particular institution with regard to patients in the various financial categories. Being well qualified in their respective fields, they serve as a healthy stimulus to the local profession. As individuals, the members of the full-time staff are generally held in high regard personally and professionally; there are many close friendships between members of the two groups.

The medical profession in general no longer questions the fact that the great burden of teaching is done more easily and effectively in a school-controlled hospital. While indigent patients may be considered essential as the most important source of teaching material, it is recognized that private patients are also necessary both for a well-rounded teaching program as well as for financial advantage to the school or to serve as an incentive to attract sufficient competent physicians to the full-time faculty. In this connection it should be stated that most schools place a ceiling on the professional income of members of its full-time faculty; ideally, funds in excess of this revert to the school for use in its teaching and research programs. Such a private service feature of the school hospital meets the demand that skills and facilities, which may not be present in a community hospital, be made available to the public on a pay basis. This service feature varies a great deal in different schools as to the extent and types of private practice in which the school engages as an institution and through members of its full-time staff.

Although the medical school occupies an important place in the community, both professionally and economically, its hospital does not, however, presume to take care of the private community sick as far as number or types of cases are concerned. The average citizen is not conversant with medical organization and finds it difficult to understand the need of modern hospital facilities for the community in addition to those of the medical school. In the case of a state supported school, the local government is prone to look upon the school hospital as a means of avoiding capital outlay for building construction for the care of the local indigent sick and also as a means of relieving it of the responsibility of financing

community hospital facilities for private patients. It is understandable that the local government would try to avoid using local tax money for medical service in the community hospital, when it could effect savings by dealings with the medical school.

While most members of the local profession are aware of the hospital needs of the community, their interests are so varied that they are unorganized, and therefore they do not present a united front in efforts to obtain them. In discussing problems of school-community relationship, some are not outspoken for various reasons, chief among which are a feeling of loyalty to the school, holding a position on the school faculty, an unwillingness to give the appearance of opposing medical education and a hesitancy about jeopardizing their personal interests. The medical school has such prestige of position as an educational institution and advantages from financial backing that its support is necessary for the success of any effort in behalf of the community hospital. A school policy recognizing the generally-accepted *domain of the community hospital* is essential to any satisfactory solution of the problem. This domain should include community services and the care of local public welfare patients to the extent necessary to make possible its operation upon a professionally adequate basis, with modern facilities.

The community must provide hospital facilities of its own. This responsibility is relieved only to a limited extent by the school hospital. The admissions policy of the school hospital operates on a referral basis, and, accordingly, its patients, particularly in the private category, are predominantly those requiring services in the specialties. The community must provide hospital care for the bulk of local private medical, surgical, obstetrical and pediatric cases. Facilities must be available also in the specialties. While many of the local specialists are well-qualified members of the faculty and nominally have full privileges in the school hospital, it is evident that in their practice, as the school hospital becomes better established and enlarges its full-time faculty, they find it increasingly difficult to obtain bed space or operating room time for their patients referred either locally or from a distance.

In order to serve the community to best advantage, the community hospital should be nationally accredited and maintain well-developed departments in the major specialties. It should be organized along educational lines and have services approved for intern and resident training. The term "major community hospital" has been used by Freymann to designate this type of institution. A working relationship with the school hospital is most desirable as regards house staff rotation and special laboratories; such relationship can be considered essential to the welfare of the community hospital in case of close proximity of the two institutions. A service limited to private patients does not prove adequate for a residency training program of increasing responsibility. Also, it does not constitute an educationally sound or a secure basis for school affiliation, as schools are extending their own activities in the private practice area as institutions as well as through individuals on their full-time faculty. Indigent cases are therefore necessary for the community hospital. Where the school is a state institution and has prior claim to state and federal supported patients, the only remaining significant source is the local tax supported cases. The community hospital considers that it has a prior claim to these. Because they are supported by local taxes they should be hospitalized from an administrative and professional standpoint in such a way as to enhance the scope and standards of hospital facilities generally available to the community. Capital outlay for building construction as well as per diem cost for the care of the local indigent sick is a tax responsibility of the community. For the community to avoid this by taking advantage of school subsidy for education is at the sacrifice of the scope and standards of medical care in the community hospital.

Resentment of the local profession is aroused when the school hospital as an institution encroaches upon the generally recognized patient domain of the community hospital or offers competition, made possible by

its subsidy, in such matters as room rates, salary scales, and contracting for community services. In any of these instances the effect upon the community hospital is to restrict the scope of its activities and to lower its standards. The result is the same, whether the action is in accordance with the school policy, or one of its stepping into the breach to save a local situation or to protect its own interests in a crisis which has been gradually developing and should have been prevented. As the community hospital is dependent almost solely upon income from patients, whether private or community welfare charges, it cannot compete with the school hospital, which is subsidized as an educational institution.

It can be mutually beneficial for the community hospital to take a part in the educational program of the school. By doing so, the community hospital raises its own standard of professional care. To the advantage of the school, a community hospital approved for residency training can make available to the educational program of the school, services in obstetric, pediatric, emergency and acute psychiatric cases, and thus complement the clinical material of the school hospital. These services in the school hospital may be limited in scope, particularly in the private patient category, by reason of its referral admission policy. In other departments the community hospital can supplement the school teaching program by providing types of cases not commonly found in a referral hospital. A "major community hospital" can strengthen the part-time faculty by making available to it adequate hospital facilities. It can increase the value of this group of specialists to the school by placing them in better position to complement the instruction by the full-time staff. This is in accord with the opinion of those who think that, in a well-balanced educational program, some of the instruction should be given by physicians outside the institutional full-time group. It should be emphasized that it is entirely possible for an adequately functioning community hospital affiliated with the school to rid the part-time faculty members of the discouraging feeling of frustration. This the community hospital would bring about by providing them with satisfactory working facilities and placing professional competition upon a more nearly equable basis, thereby relieving the single greatest source of resentment against the school. Furthermore, a strong and interested part-time faculty practicing and teaching under proper conditions would afford the school the most valuable and economical means of quickly meeting an increased teaching load occasioned by an enlargement of the student body.

While it is generally agreed that controversy is undesirable, differences in aims and points of view make it impossible to avoid it completely. In the event of encroachment by the medical school upon the domain of the community hospital, resulting in impairment of its scope and standards of service, and in the event of failure to resolve the differences by conference, the only recourse remaining to the local profession is to place the matter before the general medical profession and, under some circumstances, the public. Needless to say, such controversy should be conducted on a dignified plane and not be motivated by selfish interests.

It is inevitable that there be some overlapping of interests between the school hospital and the community hospital. This is desirable to the extent necessary for healthy professional competition. The local profession should recognize the requirements of the modern medical school for the purpose of education in a broad sense of the term. The attitude of the local profession should be generous and trusting. Members of the full-time staff should be conversant with the medical affairs of the community, particularly those which have a relationship to the school. They should have a feeling of responsibility for the welfare of the community in the solution of problems where there is a conflict of interests between the school and the community hospital.

The medical school, by reason of its prestige, influence, and financial backing, is in a position to adopt a policy which would avoid its encroaching upon the domain of the community hospital. In its operation and expan-

sion the medical school should subordinate to the medical welfare of the community certain interests of a local nature which are in competition with those of the community hospital. This would enable the community hospital to operate upon a broad basis in the various economic categories of patient care, which is necessary for it to maintain a satisfactory scope and standard of service. Furthermore, as a "major community hospital" it would be in a position to qualify for an active part in the teaching program of the school. This is in keeping with the growing realization that, with the schools now well-established as seats of learning and training centers, the next great advance in medical education should come logically through the community hospitals at the graduate and post-graduate levels. Once the chief source of friction between the school and the community hospital has been removed, the school would have the full support of the local physicians, and the medical profession would appear in a more favorable light before the public. By adopting such a policy the school would extend its educational influence in a very important field and at the same time directly benefit the community of which it is a part.

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Successful repair of bullet wound of abdominal aorta—G. B. Bradham, D. B. Nunn, and L. E. Brailsford. (Charleston) Ann Surg—155:86 (Jan.) 1962.

A case of successful repair of a bullet wound of the aorta is added to the 22 cases in the literature. Only 15% of patients with such injuries survive one hour. Immediate clinical diagnosis, swift control of the point of bleeding, and rapid blood replacement are mandatory. At laparotomy, manual compression of the proximal aorta prior to retroperitoneal dissection aids in minimizing blood loss until aortic clamps are placed proximal and distal to the wound. Debridement of arterial wound edges and continuous arterial suture technique suffice for the usual repair. Attention to possible additional wounds is emphasized, when the arterial repair is secure.

Treatment of systemic lupus erythematosus with steroids; report to the medical research council by the collagen diseases and hypersensitivity panel. G. Pickering, E. G. L. Bywaters, J. F. Danielli et al. Brit Med J—2:915 (Oct. 7) 1961.

The authors report on 107 patients with systemic lupus erythematosus who were treated with steroid hormones over a minimum period of 2 years. All the patients were given cortisone orally, 300 mg. on the first day, 200 mg. on the second day, and 100 mg. a day for the rest of the first week. Thereafter, the dose was to be adjusted to suppress all symptoms and signs of the disease without producing undesirable side-effects. In patients failing to respond to cortisone, corticotropin (ACTH) was given a trial, but administration of cortisone was to be resumed if the disease came under control. Most of the symptoms were rapidly though not permanently relieved, but the effect on the mortality rate was uncertain in the absence of a control group. There was no doubt, however, that in individual patients the drugs were temporarily life-saving. The incidence of side-effects was felt to be remarkably low, and it is suggested that larger doses of steroid than those administered to this group of patients may be given for a longer time to patients not responding to treatment. There appeared to be no therapeutic advantages in using any one form of steroid hormone, but electrolytic disturbances will be less of a problem if the delta analogues are used. The erythrocyte sedimentation rate has not been found to reflect accurately the clinical state of the patient, and it is regarded as unwise to insist on maintaining a normal sedimentation rate with larger doses than are needed to keep the patient symptom-free. The authors believe that at present patients with systemic lupus erythematosus should be treated vigorously with steroid hormones.

President's Page



In this, my valedictory page, I wish to thank all of the members of the South Carolina Medical Association for allowing me to serve you in the capacity of President. I can assure you that it is a distinct honor. It is my sincere hope that affairs of the Association have not receded, and I hope that it has made some progress this past year.

The patience of the Editor of the Journal, I wish to compliment. I have tried not to worry him too much, but I know of times when he must have been a little perturbed by my seeming negligence. The Committees, in most cases, have worked, and have looked into those things that concerned them. The Chairmen and the members of these committees, I thank for their duty well performed. I could not have wished for better cooperation from the executive office.

Now in the final analysis, we come down to the meeting. I hope that you will attend, and enjoy not only the program and the renewing of acquaintances, but the weather and the setting. The latter is of your choosing, and everything possible will be done to have it so that you can enjoy the time spent at the Beach. BUT PLEASE ATTEND THE SESSIONS, for the Program Committee has worked hard and long to get a program to please YOU.

Many, many thanks to all of you, and may we ever be alert to the fact that only we, each of us, can preserve a good IMAGE OF MEDICINE.

Charles N. Wyatt, M. D.

Editorials

Annual Meeting Next Month

The 114th meeting of the South Carolina Medical Association will be held this year at Myrtle Beach May 9, 10 and 11. All arrangements have been made for an attractive program and good service and accommodations have been promised by the management of the hotel and the satellite inns and motels. The tentative program for the meeting appears in this issue.

A large turnout is expected, and you should be among those present. This is an opportunity for a profitable and pleasurable stay at the beach, with science mixed with sociability and relaxation.

Care of Contact Lenses

In a very recent issue of the *Archives of Ophthalmology* appears an editorial on "to wet or not to wet" contact lenses. This information is important enough to pass on to the profession as a whole, most of whom will not see that publication. The burden of this editorial is that it is not necessary to keep contact lenses in solution, nor to use special solutions for their insertion. As a matter of fact the highly touted and overly expensive solutions sold in attractive receptacles and colors (for my lady and otherwise) are not only useless but actually dangerous as it has been shown that many are apparently capable of harboring various pathogenic organisms which can and do under certain conditions wreak havoc upon an eye. Enucleation as a result is not impossible. It is in the public interest that physicians should know and publicize the fact that in no case can good old tap water and ordinary cleansing measures be improved on so far as sanitation in the use of contact lenses is concerned. Manufacturers of these solutions will no doubt take exception to this statement.

When they are removed, contact lenses should be washed and dried, and kept in that condition in a clean container until inserted again in the eye without the aid of any special solution. If the lens be slightly greasy from meibomian secretion, this film is easily removed by simple washing in tap water and if necessary a bit of ordinary mild soap. Even if a little of such a washing solution or emulsion were accidentally left on the lens, it would do no harm comparable to what proteus or some other organism might do to the eye under conditions favorable for their devastating actions. This may be only a very small matter to the unconcerned, the lens being a tiny piece of plastic less in diameter than the little finger nail, but complications arising from it can assume catastrophic proportions.

J. W. J.

Papers Invited

Occasionally rumor reaches the Editor that there is some difficulty about having papers published in this Journal. Certainly this is not the case. The pages of the Journal are open to all of our members, and even to non-members, and the Editor would welcome submission of numerous papers. They need not be, and preferably should not be long and elaborate. Brief articles, case reports, comment, reviews of recent progress—all of these are very welcome material, as are items of news, such as meetings, elections, honors paid to members, and all similar things which would be of interest to some part of our readership. In fact, the Editor urges the readers of this editorial to send him any amount of material, which he would be most happy to read and review.

Publication obviously would depend upon the presence of some merit in the material sent in, and here the editorial judgement would have to prevail.

Syphilis in South Carolina

Some years ago the possibility of the presence of syphilis in a diagnostic survey of the patient was very considerable. Until the very recent past this situation changed so that the possibility of syphilis was very unlikely. This was the result of the development and applica-

tion of effective measures of control and a state of awareness of the disease in the population.

During the year 1961 there were 644 reported cases of primary and secondary syphilis in South Carolina. This compares very badly with the 282 cases reported during the year of 1960. This increase of 128% in the incidence of reported cases seems to indicate some extraordinary revival of activity of the disease or a slackening in our efforts at control. Since there has been no apparent lessening in efforts of official public health bodies to control the disease, the finger of suspicion of laxity is pointed to the practitioner.

It is not likely that this increase is due to better reporting as the methods used for finding and following syphilitic infection have not changed materially. There is probably a very real increase which should drive us all to greater care in recognizing, reporting and following any case of this "dread disease."

Apropos of this:
There was a young man from Back Bay
Whose chancre just faded away.
And now he has tabes,
And saber-shinned babies
And thinks he's the Queen of the May!

Who Runs the Association?

"It seems to me the State Medical Association is run by an entrenched hierarchy of old fogies who get into power and never get out until they die," was a statement recently made to me at a County Medical Society I was visiting as councilor.

The physician speaking was neither old nor young, probably about 35. Nor, apparently, was he speaking from a position for or against any stand of the state society. In trying to draw him out a bit it seemed to me the trouble was he felt simply that he was never consulted about any action the state society took. I think he felt "left out", ignored.

This concept is rather widely held by the younger physicians, especially by those not belonging to a large county society, and by some who do belong to a large one.

Since then I have thought long and hard about this problem and I have finally concluded that there are at least two obvious truths involved.

One is that we tend to regard anyone younger than we are (whatever our age) as awfully young and inexperienced so far as being old enough and experienced enough to run the state association is concerned. It is a terribly difficult thing to turn loose, especially if we know we have done a good job for years. It is awfully hard to:

Grow old along with me
The best of life is yet to be,
The last of life, For which the first was made — etc.,

so there is perhaps a touch of truth in the "entrenched hierarcy" idea.

But the second idea is the pertinent one. And that is that one must understand how one becomes a member of the hierarchy. *Some* group *must* have and use the power of running the society or the society will not "run". And whoever that group is constitutes the hierarchy. THAT GROUP IS THE HOUSE OF DELEGATES, *representing the county medical societies,* AND COUNCIL, the executive committee of the house of delegates. The house of delegates is the all-powerful group. And virtually all, if in fact not all, of the actions of the house of delegates originate in the county medical societies.

Some counties don't even have a county medical society. Some county societies that do exist meet infrequently and irregularly. Some that meet regularly spend much time on refreshment and pay little attention to business. Many members of the Medical Association never read our *Journal* and have no idea what is going on.

All of this is merely repetition of what our recent president, Dr. Joe Cain, preached all during his term as president. (And Dr. Cain, by the way, is one of the more influential members of our society. I wonder how many of us realize he is from one of the smaller county societies of the state.)

I feel sure that in every county there is at least one physician who would like to be active in organized medicine, at least one who would like his opinion counted. And it is primarily to him, wherever he is, and to the man who made this opening statement above

to me to whom I particularly write this. If you want organized medicine to know you are alive, read the state medical journal, *attend your county medical society meetings* and, if you have anything to say, say it. If you do not have a county medical society ORGANIZE one or attend the meetings of the nearest county society in the state. ATTEND YOUR DISTRICT MEDICAL SOCIETY meetings and do not hesitate to express your (considered) opinions. If you are a delegate to the state meeting *be there* and participate. If you are on a committee, whether county, state, or house of delegates, be there and work. And do you know what will happen? The first thing you know you will find yourself a member of the hierarchy. It will take a few years because you will have to prove yourself over a period of years. You will have to show that you are informed, that you are mature, that you are willing and able to do a good job. And by then you may be a little old (50?) and you may be damned by the younger physicians (anyone under 50?) as a member of the "entrenched hierarchy"!

The answer all boils down to whether we (seriously) attend our county medical societies' meetings, the district meetings, the state meetings, and read the *Journal's* editorial page.

Norman Eaddy, M. D.

On Presenting Papers

Ineffectual presentation can make the best paper worthless, as far as the audience is concerned. Outstanding presentation can make a mediocre paper appear exceedingly impressive.

In preparing your oral presentation, keep in mind these facts:

1. THE LISTENER SATURATES far more readily than the reader; the listening audience will hear with comprehension only if your talk is carefully timed and paced; use short sentences; talk slowly as in conversation; pause for digestion of facts, especially when more difficult concepts are presented.
2. A TALK IS NOT A PAPER. Members of the audience may read your paper later. Your job is to make them listen to your talk. To accomplish this, do not commit your talk to memory. Don't plan to read it. Plan to talk about the essential features of your paper.
3. *Commit the essential features of your paper to memory; write them down; then talk about them; talk about them to your associates; talk about them to yourself; talk about them to a tape recorder. Time yourself. Then you are ready to talk about them to your audience.*
4. TIMING: timing is best achieved by rehearsal; a 20 minute oral presentation will consist of 2500 to 3000 words, that is about 10 double spaced pages of typing.
5. TIMING: timing to match your listeners' ability to follow and comprehend will come automatically if you think as you talk; that is, if you talk about the essential ideas in your paper. Practice doing this.
6. SLIDES: slides must be simple and must be comprehended at a glance; there is no time to read sideways; there is no time to decide which label applies to which curve; no lettering should be smaller than one-twentieth the total height of the drawing. It is essential that all slides be sequentially numbered for the projectionist.

If each slide presents a simple concept, is uncluttered, has large legible letters and is easy to read, it will help your talk immeasurably. In using it, observe the following rules:

a) Allow the audience several seconds to study the slide before you begin talking about it. Remember, the audience cannot study the slide and listen to you at the same time.

b) Don't turn your back on the audience, study the slide and talk all at the same time. It is helpful to have all your slides duplicated on paper. The paper duplicates can then be stacked on the rostrum in the same order as you stack the slides at the projector.

c) Use each slide only once. If you must refer to the same slide at different times in your talk, use duplicate slides if possible. This will eliminate fumbling and possibly showing the wrong slide.

d) Hurried blackboard illustrations are seldom legible and are often confusing.

Your talk will be effective only if you communicate with your audience. You won't communicate if you read your paper or if you deliver your talk from memory at a rapid pace. Talk to your audience as though you were talking to your wife, your boss or to someone under your supervision.

1. Speak in a conversational manner. Make each member of your audience feel that you are speaking directly to him.

2. Take your time, pause between ideas to make sure that you are "getting thru".

3. Think along with your audience as if this were the first time you yourself had heard the material.

4. Observe the physical requirements for a good presentation. These include standing in a normal and alert position, breathing as deeply as possible and looking at your audience. In looking at your audience, remember that it is distributed throughout the entire room and that you must shift the direction of your gaze as often as you can in a natural manner.

5. DON'T READ.

From *Techniques for Better Talks—Institute of Radio Engineers.*



ONE HUNDRED AND FOURTEENTH ANNUAL MEETING OF THE

SOUTH CAROLINA MEDICAL ASSOCIATION

MYRTLE BEACH, MAY 8, 9, and 10, 1962

GENERAL PROGRAM

TUESDAY, MAY 8

9:00 A. M. Meeting of Council
2:30 P. M. House of Delegates (Ball Room)
5:30 P. M. Meetings of Reference Committees

WEDNESDAY, MAY 9

9:30 A. M. House of Delegates Resumes (Ball Room)
11:00 A. M. Scientific Film (TV Room)
12:15 P. M. Adjournment Sine Die
12:30 P. M. Alumni Luncheon (Main Dining Room)
2:00 P. M. Scientific Session (Ball Room)
9:00 P. M. Alumni Association Entertainment (Ball Room)

THURSDAY, MAY 10

9:00 A. M. Scientific Session Resumes
12:30 P. M. Luncheon Recess
2:00 P. M. Scientific Session Resumes
5:30 P. M. Adjournment
8:00 P. M. Annual Banquet and Ball for Alumni Association and Guests

HOUSE OF DELEGATES

Dr. Charles N. Wyatt, Presiding

TUESDAY, MAY 8

2:30 P. M. Call to Order
Invocation
Report of Credentials Committee
Opening Remarks by the President
Introduction of President-elect
Announcement of Reference Committees
Presentation of Resolutions and Recommendations

3:15 P. M. Introduction of Officers and Guests of Woman's Auxiliary
Reports of Officers
The President
The Executive Secretary
The Secretary
The Treasurer
The Editor of the Journal
The Chairman of Council
The Delegates to the A. M. A.

4:30 P. M. (Special Order) The Annual Meeting of the Corporation, The South Carolina Medical Care Plan
Reports of Committees
(The reports of the Committees will have been published in the Journal and will not be read before the House. Any supplementary remarks by the Chairmen will be heard at this time.)
Report of State Board of Medical Examiners
Report of Executive Committee of State Board of Health
Unfinished Business
New Business

5:30 P. M. Meetings of Reference Committees
(All members of the Association are invited to appear before the Committees considering matters in which they are interested. Meeting places will be posted and announced.)

WEDNESDAY, MAY 9

9:30 A. M. Call to Order
Reports of Reference Committees

11:30 A. M. Annual Elections
Officers:
President-Elect
Vice-President
Secretary
Treasurer
Delegate to the A. M. A.: (2-yr. term)
(The term of Dr. George Dean Johnson expires December 31, 1962.)
Alternate Delegate to the A. M. A.: (2-yr. term)

(The term of Dr. Charles N. Wyatt expires December 31, 1962.)
Councilors: (3-yr. terms)
Third District—(The term of Dr. C. J. Scurry expires.) (1957)
Sixth District—(The term of Dr. William L. Perry expires.) (1959)
Ninth District—(The term of Dr. John M. Fleming expires.) (1956)
Members of Mediation Committee:
Third District—(The term of Dr. Martin M. Teague expires.) (1956)
Sixth District—(The term of Dr. Sam O. Cantey expires.) (1959)
Ninth District—(The term of Dr. Harold P. Hope expires.) (1956)
Benevolence Fund Committee Member—(3-yr. term) (The term of Dr. O. B. Mayer expires)
Members of the State Board of Medical Examiners: (4-yr. terms)
Fourth Congressional District (The term of Dr. George R. Wilkinson expires.)
State at Large (The term of Dr. W. R. Tuten expires.)
Members of Hospital Advisory Council of the State Board of Health—(4-yr. terms)
(The term of Dr. Pierre F. LaBorde, Jr. expires)
Member of State Board of Nursing Examiners—(5-yr. term)
(The term of Dr. Wyman W. King expires.)
Selection of Place for the 1963 Annual Meeting.
Sine Die Adjournment

SCIENTIFIC SESSION

Presiding: DR. CHARLES N. WYATT, President

WEDNESDAY AFTERNOON — MAY 9, 1962

2:00 Arthritis; From the Gross Osteopathologic and Orthopedic Viewpoints.
William J. Tobin, M. D., Associate Professor, Orthopedic Surgery, Georgetown University School of Medicine.

2:45 Treatment of the Comatose Patient.
V. K. Stoelting, M. D., Professor of Anesthesiology, Indiana University School of Medicine.

3:30 Break to view exhibits.

3:45 Prevention and Management of Pulmonary Complications in Surgical Patients.
John D. Ashmore, Jr., M. D., General Surgeon, Greenville, S. C.

4:15 Accident Prevention.
George M. Wheatley, M. D., Head, Health and Welfare Division, Metropolitan Life Insurance Company.

5:00 Adjourn

THURSDAY MORNING — MAY 10, 1962

9:30 Hypercalcemia — A clinical spectrum.
John V. Verner, Jr., M. D., Associate in Medicine, Duke University, School of Medicine.

10:15 Laboratory Aids in Hematologic Problems.
Doris A. Howell, M. D., Associate Professor of Pediatrics and Pediatric Hematologist, Duke University, School of Medicine.

11:00 Break to view exhibits.

11:15 Respiratory Embarrassment other than Cardiac.
Herbert O. Sieker, M. D., Professor of Medicine, Duke University, School of Medicine.

THURSDAY NOON — MAY 10, 1962
12:00-2:00 — LUNCHEON DISCUSSIONS

☐ A. PSYCHOSOMATIC MEDICINE FROM THE VIEWPOINT OF THE PRACTITIONER.
John V. Verner, Jr., M. D., Durham, N. C.
William C. Miller, Jr., M. D., Charleston, S. C.
James C. Vardell, Jr., M. D., Columbia, S. C.

☐ B. THE PEDIATRIC PATIENT WITH LEUKEMIA.
Doris A. Howell, M. D., Durham, N. C.
Albert Cannon, M. D., Charleston, S. C.
Walter M. Hart, M. D., Florence, S. C.

☐ C. PNEUMONIA, A CURRENT PROBLEM.
Herbert O. Sieker, M. D., Durham, N. C.
Kelly T. McKee, M. D., Charleston, S. C.
Wilson Greene, Jr., M. D., Sumter, S. C.

☐ D. SUDDEN DEATH IN INFANTS.
Thomas D. Kinney, M. D., Durham, N. C.
Arthur E. Dreskin, M. D., Greenville, S. C.
Margaret Q. Jenkins, M. D., Charleston, S. C.

☐ E. SURGICAL EMERGENCIES.
Guy L. Odom, M. D., Durham, N. C.
George M. Wheatley, M. D., New York, N. Y.
R. Randolph Bradham, M. D., Charleston, S. C.
William C. Cantey, M. D., Columbia, S. C.

☐ F. THE THYROID PROBLEM.
William M. Nicholson, M. D., Durham, N. C.
John F. Buse, M. D., Charleston, S. C.
William H. Prioleau, M. D., Charleston, S. C.

☐ G. OFFICE ORTHOPEDICS.
William J. Tobin, M. D., Washington, D. C.
John A. Siegling, M. D., Charleston, S. C.
Frank H. Stelling, M. D., Greenville, S. C.

☐ H. OBSTETRICAL ANESTHESIA.
V. K. Stoelting, M. D., Indianapolis, Ind.
Edward J. Dennis, M. D., Charleston, S. C.
Charles H. Poole, Jr., M. D., Spartanburg, S. C.

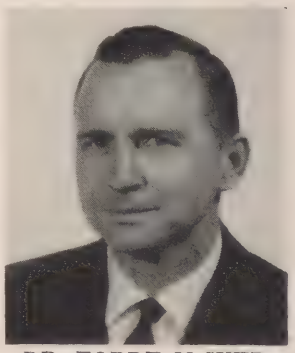
THURSDAY AFTERNOON — MAY 10, 1962

2:15 Medical Emergencies — Panel
Wm. M. Nicholson, M. D., Moderator
Doris A. Howell, M. D.
Guy L. Odom, M. D.
Herbert O. Sieker, M. D.
John V. Verner, Jr., M. D.

3:45 Break to view exhibits.

4:00 Clinico-Pathological Conference
Clinical Presentation—Guy L. Odom, M. D.
Pathologic Presentation—Thomas D. Kinney, M. D.

5:00 Adjourn



DR. FORDE McIVER
Program Chairman

PLEASE NOTE!

THOSE WHO WISH TO ATTEND THE
LUNCHEON DISCUSSION PANELS
MAY 10, 1962

Attendance is limited to 21 members at each luncheon group.

Indicate order of preference in box beside each panel group and return to Dr. McIver.

Pick up tickets at registration desk.

Mail requests for registration to:
Forde A. McIver, M. D., Chairman
Program Committee
16 Lucas Street
Charleston 16, S. C.

Cost of luncheon included with accommodations at Ocean Forest Hotel. For those not staying at the hotel, the cost is $2.75 (including tax and gratuity).

South Carolina Participants

Panel Members representing the Medical College of South Carolina.

Panel Members representing the South Carolina Medical Association.

James C. Vardell, Jr., M. D.
Dr. Vardell obtained his M. D. degree from Duke University School of Medicine in 1947. He practices internal medicine in Columbia, South Carolina.

Albert Cannon, M. D.
Dr. Cannon obtained his M. D. degree from the Medical College of South Carolina in 1949. He is currently Assistant Professor in Clinical Pathology at the Medical College in Charleston, South Carolina.

Walter M. Hart, M. D.
Dr. Hart obtained his M. D. degree from the Medical College of South Carolina in 1941. He practices pediatrics in Florence, South Carolina.

Kelly T. McKee, M. D.
Dr. McKee obtained his M. D. degree from the University of Virginia in 1941. He is now Associate Professor of Medicine at the Medical College in Charleston, South Carolina.

Wilson Greene, Jr., M. D.
Dr. Greene obtained his M. D. degree from the Medical College of South Carolina in 1945 and practices internal medicine in Sumter, South Carolina.

Arthur E. Dreskin, M. D.
Dr. Dreskin obtained his M. D. degree from Tulane University School of Medicine in 1943. He is engaged in the practice of pathology in Greenville, South Carolina.

Margaret Q. Jenkins, M. D.
Dr. Jenkins obtained her M. D. degree from the Medical College of Georgia in 1949. She is now Assistant Professor of Pediatrics at the Medical College in Charleston, South Carolina.

R. Randolph Bradham, M. D.
Dr. Bradham obtained his M. D. degree from the Medical College of South Carolina in 1951. He is now Associate Professor of Surgery and Acting Chairman of the Department of Surgery of the Medical College in Charleston, South Carolina.

William C. Cantey, M. D.
Dr. Cantey obtained his M. D. degree from the Medical College of South Carolina in 1936. He practices general surgery in Columbia, South Carolina.

John F. Buse, Jr., M. D.
Dr. Buse obtained his M. D. degree from the Medical College of South Carolina in 1953. He is now Assistant Professor of Medicine at the Medical College in Charleston, South Carolina.

William H. Prioleau, M. D.
Dr. Prioleau obtained his M. D. degree from Johns Hopkins University School of Medicine in 1923. He

is now Clinical Professor of Surgery at the Medical College of South Carolina and practices general surgery in Charleston, South Carolina.

John A. Siegling, M. D.

Dr. Siegling obtained his M. D. degree from the Medical College of South Carolina in 1932. He is now Clinical Professor of Orthopedic Surgery and Chairman of the Department of Orthopedics at the Medical College of South Carolina and practices orthopedic surgery in Charleston, South Carolina.

Frank H. Stelling, M. D.

Dr. Stelling obtained his M. D. degree from the University of Georgia in 1938. He practices orthopedic surgery in Greenville, South Carolina.

Edward J. Dennis, M. D.

Dr. Dennis obtained his M. D. degree from the Medical College of South Carolina in 1948. He is now Associate Professor of Obstetrics and Gynecology at the Medical College in Charleston, South Carolina.

Charles H. Poole, Jr., M. D.

Dr. Poole obtained his M. D. degree from Jefferson Medical College in 1937. He practices Anesthesiology in Spartanburg, South Carolina.

William C. Miller, Jr., M. D.

Dr. Miller received his M. D. degree from the Medical College of South Carolina in 1953. Having completed training in both internal medicine and psychiatry, he is now Instructor in Medicine and Psychiatry.

Invited Speakers

William M. Nicholson, M. D.

Dr. Nicholson graduated from Johns Hopkins University School of Medicine in 1931. He came to Duke University Medical Center in 1935 as Instructor in Medicine and Biochemistry. At the present time he is Professor of Medicine, Physician to Duke Hospital, and Assistant Dean in charge of Post-Graduate Medical Education at Duke University. Dr. Nicholson's interest in diseases of the thyroid gland has extended over many years.

Herbert O. Sieker, M. D.

Dr. Sieker obtained his M. D. degree from Washington University School of Medicine, St. Louis, Missouri, in 1948. At the present time he is Professor of Medicine at Duke University School of Medicine, Consultant to the Veterans Administration Hospital in Durham and Fayetteville and Consultant to the U. S. Army Hospital at Fort Bragg, North Carolina. Dr. Sieker has published fifty-five articles, many of which are related to the field of cardiorespiratory function.

John D. Ashmore, Jr., M. D.

Dr. Ashmore received his M. D. degree from the Medical College of South Carolina in 1953. He served as Research Fellow at the Medical College Hospital in Charleston in 1954-1955 and as Teaching Fellow in Surgery in 1957-1958. At present, Dr. Ashmore is practicing general surgery in Greenville, South Carolina. His list of publications reflects an interest in both thoracic and abdominal surgery.

V. K. Stoelting, M. D.

Dr. Stoelting received his M. D. degree from the Indiana University School of Medicine in 1936. After training in Anesthesiology at the University of Wisconsin and the University of Iowa, he served in the Medical Corps from 1942 to 1946 where he obtained the rank of Major and then returned to the Indiana University Medical Center where he is currently Professor and Chairman of the Department of Anesthesiology.

Guy L. Odom, M. D.

Dr. Odom obtained his M. D. degree from the Tulane Medical School in 1933. After gaining experience at the East Louisiana State Hospital, the Montreal Neurological Institute, and Louisiana State University, Dr. Odom came to Duke University School of Medicine in 1942 where he was made Professor of Neurosurgery in 1950 and Chairman of the Department in 1960. His special medical interests include brain tumors and cerebral vascular problems.

William J. Tobin, M. D.

Dr. Tobin graduated from the Medical College of South Carolina in 1935. At the present time he is civilian consultant to the U. S. Naval Hospital, Bethesda, Maryland and the Walter Reed Army Hospital, Washington, D. C. He is Associate Professor of Orthopedic Surgery at Georgetown University School of Medicine. In addition to holding membership in numerous scientific societies, Dr. Tobin is an Honorary Collaborator in the Division of Physical Anthropology, U. S. National Museum, Smithsonian Institution, Washington, D. C. His special medical interests include research in the antiquity of bone diseases, bone architecture and gross osteopathology.

John V. Verner, Jr., M. D.

Dr. Verner received his M. D. degree from Duke University School of Medicine in 1954. After training at Duke University and the University of Michigan Schools of Medicine, he was appointed Associate in Medicine at Duke University School of Medicine in 1959. Dr. Verner's list of publications reflects an extensive interest in metabolic disorders and infectious diseases with fluid and electrolyte disturbances.

George M. Wheatley, M. D.

Dr. Wheatley graduated from Harvard Medical School in 1933 and received his Master degree in Public Health from Columbia University in 1942. He is the first Chairman of the Accident Prevention Committee of the American Academy of Pediatrics, of which he is the immediate Past President, and helped to develop a number of programs for the prevention of accidents to children, particularly the present information center concept. Dr. Wheatley is third vice-president and Medical Director of the Metropolitan Life Insurance Company and has been

head of its Health and Welfare Divisions since 1959.

Doris A. Howell, M. D.

Dr. Howell received her M. D. degree from McGill University Medical School, Montreal, Canada in 1949. After training at Children's Memorial Hospital, Montreal, Duke Hospital, Harvard Medical School, and Children's Medical Center, Boston, Massachusetts, she joined the Staff of the Duke University School of Medicine where she is now Associate Professor of Pediatrics and Pediatric Hematologist.

Thomas D. Kinney, M. D.

Dr. Kinney received his M. D. degree from Duke University School of Medicine in 1936. After a series of teaching appointments at Yale University, Boston University, Tufts College Medical School, Harvard Medical School, and Western Reserve University School of Medicine, he was named Professor of Pathology and Chairman of the Department of Pathology at Duke University Medical Center in 1960.

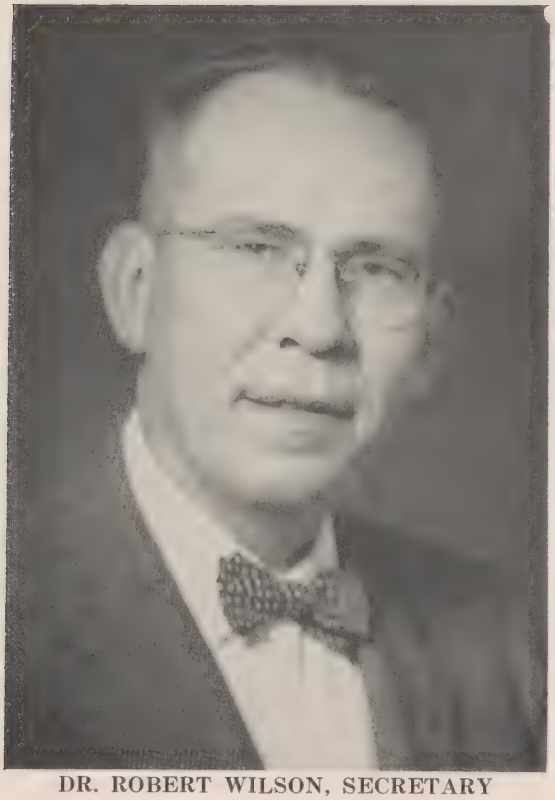
Dr. Kinney is editor of *Laboratory Investigation* and a consultant for the Armed Forces Institute of Pathology. His special medical interests include research in nutritional pathology.



DR. CHARLES N. WYATT
PRESIDENT



DR. WALLIS CONE
VICE-PRESIDENT



DR. ROBERT WILSON, SECRETARY



DR. HOWARD STOKES, TREASURER

Committee Reports

Committee on Legislation and Public Relations

Matters of interest to the South Carolina Medical profession that came to the attention of your Committee during the past year were the following:—

"Good Samaritan Law". This is a law in some states which protects a doctor who stops at a roadside accident and renders aid. The American Medical Association does not encourage the enactment of such legislation and your Council has taken no action to have such a law enacted.

"Medical Retirement Fund" or "Doctor Corporation" Law. There are laws in some States that permit a Medical Doctor to incorporate and set aside funds up to a certain amount each year until he retires. This fund is deductible until it is drawn after retirement. The Columbia Medical Society requested Senator Walter Bristow to introduce such a bill, which he did. The South Carolina Medical Association Council felt it was unwise to push such legislation so the bill was allowed to languish. The Columbia Medical Society did not push it as it was felt that a solid front was necessary for successful action.

"Osteopathic Bill". The osteopaths had Senator Jessen introduce a bill which would have virtually allowed them to practice medicine. A hearing was held before the Senate Committee to which it was referred and attending the hearing were representatives of the osteopaths, the S. C. Hospital Association and the S. C. Medical Association. Attending for the S. C. Medical Association were Drs. Charles Wyatt, President; Dr. John Brewer, Chairman of Council; Dr. Toolie Gressette, President Elect; Dr. Frank Owens, Chairman, Legislative Committee and Mr. Jack Meadors. Indications were that the bill would be held in committee.

In view of the importance of National Legislation affecting the Medical Profession and the voluminous literature sent out concerning such legislation, it is recommended by the Chairman of this committee (though not cleared with the members) that a Co-chairman of this Committee be appointed whose duties will be in the field of National Legislation.

Respectfully submitted,
Frank C. Owens, Chairman

Medical Advisory Committee To Selective Service

Selective Service throughout the country was called upon to furnish 840 doctors for induction prior to February 1962. The calls necessary to furnish these men were for doctors born after June 30, 1934. Five South Carolina doctors were affected. As of this writing no additional calls have been made. Doctors

completing their internship will furnish an additional pool from which Selective Service might draw.

Requests for the opinions of your committee on the essentiality of two men were made. One of these was declared available and the other was declared essential to the community for a period of six months to allow the Community to secure a replacement.

Your Committee continues to function on a stand-by basis.

Respectfully submitted,
Frank C. Owens, Chairman

Committee on Infant and Child Health

The members of this committee were furnished a copy of the report on Committee on Fetus and Newborn of the American Academy of Pediatrics, regarding Neonatal Jaundice, in June of 1961. All members of this committee were urged to present the subject matter at medical society meetings, staff meetings or any other medical meetings at which they were asked to speak.

We thought that this material would be interesting to obstetricians, general practitioners and pediatricians. Reports are that the material was well received at the meetings at which it was presented.

A more complete report of this committee's activities will be presented at the regular meeting of the South Carolina Medical Association in May, since this committee will meet in Columbia on February the 28th.

At that time, the results of the committee's Study on Neonatal Deaths in 1958, '59 and '60 will be discussed. The work on this death study has been done primarily by Dr. Walter Hart and he states that the results are near completion.

Respectfully submitted,
John W. Rheney, Jr., M. D., Chairman

Supplemental Report
Committee on Infant and Child Health

This Committee met at the Columbia Hotel on February 28th, in conjunction with the Committee on Fetus and Newborn, South Carolina Chapter, American Academy of Pediatrics. Eight members were present.

The first order of business was the presentation of the Neonatal Death Study for 1958, '59 and '60, by Dr. Walter Hart. It was impossible in the allotted time to fully discuss all features of this monumental work; however, some of the most important points study were brought up and discussed. The Committee wishes to express to Dr. Walter Hart their deep appreciation for the untold hours he spent in compiling this report.

Among the points brought to light in this study which the Committee wishes to bring to the attention of the Association are several deficiencies in the handling of newborn infants at the various hospitals:

1. Of the more than 1100 deaths reported in this study, it was noted that in over 250 or nearly 25 per cent, there was no Rh Factor determination on the mother of the child named in the report. We feel that Rh Factor determination should be as routine as serology and hemoglobin determination in pregnant women.

2. It was also noted that the autopsy rate was extremely low in some areas. It is assumed that this low autopsy rate can be explained by the fact that a number of these deaths were in very small prematures, however, the Committee would encourage the obtaining of autopsies in infants whether premature or full term, if there is some doubt as to the cause of death.

It was decided that the salient features of each hospital's report would be abstracted and these features reported to the individual hospitals which comment about the reports or about improving services to premature and newborn infants in these institutions.

The next order of business was discussion of the value of presenting the American Academy of Pediatrics' report on Neonatal Jaundice to the various medical societies. It was reported that reception was good where these reports had been given and it was decided that the stressing of the causes of neonatal jaundice would be continued during the coming year by this committee. Copies of the report on neonatal jaundice will be redistributed to all members of this committee, so that information can be passed on to the various medical societies. It was suggested that, if possible, some time in the future that a panel discussion on neonatal jaundice be presented at a regular meeting of the South Carolina Medical Association. Dr. Hart is to work out the details for this presentation.

After discussion of other proposed projects for this committee in the future, it was decided that the committee would meet again in the fall and the meeting was adjourned.

John W. Rheney, Jr., M. D., Chairman

Committee on Care of The Aging

The committee on Care of the Aging of the South Carolina Medical Association met in Columbia on Sunday, November 19, 1961. Dr. Thomas Parker of Greenville, Dr. Martin M. Teague of Laurens, and I were present. It was impossible for Dr. Boone to attend the meeting.

The following recommendations were adopted by the committee:

1. We strongly recommend that each individual facing retirement be thoroughly prepared for the eventuality well in advance.
2. We disapprove the compulsory retirement of individuals at the age of 65, and we urge that the Medical Association do all in its power to educate management on this subject. Also, that an effort be made at re-employment of persons over the age of 65 when they are capable of continuing in active work.
3. The committee urges the Association to endorse the development of housing communities for the aging along with private nursing homes to care for the aged individuals that cannot be kept at

home. We realize that this requires quite an outlay of money and that possible private donations added to government aid for nursing could be established in this State along with the housing communities.

4. We urge the South Carolina Medical Association to endorse the development of Golden Age Clubs, and recommend that the Woman's Auxiliary continue to sponsor this program.
5. Through the Visiting Nurses Program of the South Carolina Health Department or some similar agency we urge further development of home care service. This could be of great assistance to physicians caring for the elderly population who are fortunate enough to remain at home.

R. L. Crawford, M. D., Chairman

Committee on Cancer

The Committee on Cancer of the South Carolina Medical Association was appointed by the President in May, 1961 consisting of Drs. Leland Brannon, Edward Cardwell, James R. Young, Elbert DeVore, Jennings Owens, Rufus Nimmons, Murray Jackson, Donald Kilgore, Jr. and with the undersigned as chairman.

As chairman of this Committee in 1960, I was unable to find out the duties or assignments of this Committee and it was therefore inactive.

The same has been the case in 1961. As stated last year, the previous reports have been largely statistical regarding Statewide Cancer Clinics and their patients and it is again felt that these figures are duplicates of those published elsewhere and are not duplicated here.

Again, unless there is some concrete project or assignment for this Committee, it is suggested that it be eliminated.

Respectfully submitted,
William C. Cantey, M. D., Chairman

Committee to Study Current Efforts and Facilities of the AMA Along Public Relations Lines

This Committee has functioned through the public relations program of the Association. As our public relations activity is in close touch with the American Medical Association's public relations department, there seems to be little need for this committee as long as our public relations activities are continued.

J. I. Waring, M. D., Chairman

The Medical Advisory Committee to the Crippled Children Society of South Carolina

This Committee has served actively the cause of the Society, working largely through the efforts of individual members. Your chairman has been elected one of the vice presidents for the Society, and has participated in a number of meetings. Other members have been very helpful to the Society in promoting local activities or helping in solving local problems.

The Committee is still of the opinion that the Crippled Childrens Society functions in a very satisfactory and worthwhile manner, and has only praise for its activity.

J. I. Waring, M. D., Chairman

Liaison Committee

The South Carolina Medical Association Liaison Committee met with Messrs. Rivers, Dean and Cherry of the Department of Public Welfare in Columbia, March 31, 1961. A report of this meeting was submitted to Dr. Joseph Cain, at that time president of the Association.

Many problems were discussed and a clear understanding was apparently reached on all matters that were causing friction.

On October 29, 1961, letters were sent to all members of the committee and to Mr. Arthur Rivers asking them if anyone knew of a need for a meeting of the committee and if anyone knew of a conflict that needed discussion or investigation. No one has answered my letters, so I have assumed that relations between the Department of Public Welfare and the South Carolina Medical Association are highly satisfactory.

Harold S. Pettit, Chairman

Committee To Study Injuries From Lead Pellets

Efforts to secure some idea of the magnitude of the problem of injuries by lead pellets in South Carolina at the present time by requests made through the Journal of the South Carolina Medical Association have so far been unrewarding. Inquiry through the National Society for the Prevention of Blindness has yielded valuable information and suggestions. Further efforts should be made to collect information of all types from physicians, hospitals, clinics, and school systems as to injuries due to air rifles and similar weapons. Results can be used to stimulate interest in educational programs to prevent such injuries.

It can be unequivocally stated that not a month goes by without the loss of one or more eyes in South Carolina from injuries from BB guns, shot guns, or pump guns. Though the BB shot are ordinarily now made of steel and are easily removed, they do enormous damage, and where they have penetrated the globe, the eye is usually lost in spite of all that can be done.

As this committee sees the problem, it is not so much a question of trying to get rid of the sources of trouble, which will probably be impossible, as it is of promoting the education of the public as to the real and present dangers to the eyes of children and adults, participants and bystanders. This matter is so important that we feel that a continuing committee should be appointed to keep up with advances elsewhere, and to promote, and possibly design ways and

means for avoiding these dreadful and needless injuries to the greatest possible extent.

Respectfully submitted,
J. W. Jervey, Jr., Chairman
Pierre G. Jenkins
David S. Asbill

The Committee on Historical Medicine

This Committee has continued its activities in gathering information and is well along in its construction of a book. It is expected that the book on The History of South Carolina Medicine up to the period 1825 will be ready by the latter part of this year.

The Association has been kind in the past in setting aside annually $500.00 toward eventual publication of this book. The Committee will request that one more appropriation of this same magnitude will be made for the period 1962-1963, in order to provide an adequate amount for publication costs.

It will be remembered that the money accumulated in the past has not been spent, except for a few minor expenses, and that it will be returned to the Association if the book is not completed. If this book covering the period up to 1825 is completed, the Committee recommends that the work be continued to bring the subject up to recent date.

J. I. Waring, M. D., Chairman

Committee on Liaison with Allied Professions

No business was presented for the Committee to act upon and therefore no meeting was held. It would appear desirable that in future years a small appropriation be made for the purpose of organizing a meeting with representatives of the allied professions. There is a need to establish closer liaison at a state level for the purpose of meeting and discussing mutual problems and goals. Such a venture would entail limited expenditures and could be extremely valuable.

Respectfully submitted,
Harold E. Jervey, Jr., Chairman

Committee on School Health

The School Health Committee of the South Carolina Medical Association met several times during the past year. The major function for the year is the annual School Health Conference, and this event was planned for this year for March 29th at the Jefferson Hotel.

The conference last year was attended by some 20 odd general practitioners and pediatricians, mostly the latter and several health officers, and a few educators. The guest speaker at the conference was Dr. Donald Dukelow. His paper "A Suggested Medical Association School Health Program" was published in the September 1961 issue of the Journal of the South Carolina Medical Association.

There has been greatly increased interest in the subject of School Health, particularly in the South Carolina Chapter of the American Academy of Pediatrics. Dr. Willard Mills is the chairman of the School Health Committee of that organization. He has made every member of that group an ex officio member of the chapter of the School Health Committee, and he is very actively encouraging pediatricians to attend the conference this year so that they may be oriented and stimulated to participate actively in their local School Programs. The meeting planned for March 29th was to be in the form of a working conference. There will be introductory remarks by several local speakers, and then the meeting will be subdivided into four workshops which will deal with various facets of problems of mutual interest to doctors and educators in local school situations.

Respectfully submitted,
J. R. Paul, Jr., M. D., Chairman

Committee on the Woman's Auxiliary of the Medical Association

This committee had a relatively quiet and inactive year. The only problem which has come up will require the action of the S. C. Medical Association, I believe. The National Woman's Auxiliary has issued a directive advising the various State Auxiliaries to undertake the formation of a political activity committee. This committee would be affiliated with, and under the direction of, the political activity committee of the state Association or a reasonable facsimile thereof. I do not believe that the South Carolina Medical Association has a political activity committee. Therefore, I would like to have the House of Delegates indicate whether they are interested in appointing a political activity committee which would cooperate with the Woman's Auxiliary political activity committee to be appointed or whether you would prefer to let the whole matter drop.

R. W. Hanckel, M. D., Chairman

Committee on Rehabilitation

No formal report or recommendations submitted.

It appears that this committee as now constituted has very limited function and should either be reorganized, combined with another appropriate committee or discontinued. Request to appear before the Reference Committee for further discussion of this will be made at the Annual Meeting at Myrtle Beach, S. C.

Harry W. Mims, M. D., Chairman
Ben N. Miller, M. D.
John K. Webb, M. D.
Charles B. Thomas, M. D.
Roderick MacDonald, M. D.

The Industrial Medical Committee

This Committee has not met this year. The Chairman and Dr. John Perry have been in constant contact with each other concerning the various activities and proposed action of this committee.

Dr. Perry has been the representative of the committee at several of the Industrial Meetings throughout the nation during the year. He has attended the

National Industrial Health Conference in Los Angeles; The Congress on Occupational Health, of the American Medical Association, in Denver; The Carolina Industrial Medical Association Meeting, at Myrtle Beach; and the Annual South Carolina Accident-Prevention Conference in Columbia.

Efforts are being made to increase the membership and the actual participation of members in this committee activity. One of the most important moves was the joining of the South Carolina and North Carolina Industrial Medical Associations to form the Carolina Industrial Association. It is felt that through this organization the committee will be able to have better contact with the various individuals working in industrial health throughout the two Carolinas. It will also give us the opportunity for a closer working arrangement with the National Industrial Health organizations.

The Carolina Industrial Medical Association held its meeting at Myrtle Beach on Sunday, October 29, 1961 and representatives of industry and medicine were present from both South and North Carolina. The meeting was well presented with numerous problems concerning industrial health being discussed.

The revised fee schedule for those handling Industrial Commission cases has been sent to the Industrial Commission, but as yet there has been no final action on these, as far as this Chairman can determine.

It is hoped that the forthcoming meeting of the South Carolina Medical Association will give us an opportunity to further increase the interest of those serving Industry in Medicine for the state and further improve the general working order of this important facet of South Carolina's Medical Care with its increasing industrialization.

George C. Smith, Chairman

Accident Prevention Committee

The South Carolina Medical Association Accident Prevention Committee met in Columbia on September 11, 1961. At this time there was much confusion among the members present as to the committee's functions and actual status. It was brought out that the committee had previously been appointed temporarily by the state Medical Association's President for the specific purpose of working with the State Board of Health on the problem of passage of a hazardous substance law, and subsequently it had been asked to investigate and make recommendations of the Cornell Crash Injury Project to the State Board of Health and the State Medical Association prior to the annual meeting of 1961.

The President and Executive Secretary of the Association were contacted by letter to determine the actual functions and status of the aforementioned committee and it was soon learned that said committee had no actual status and was only a temporary advisory committee. Since it was felt that a broader field of activity in accident prevention with official approval of the state Medical Association was



DR. J. H. GRESSETTE, PRESIDENT-ELECT

necessary, the chairman of this committee and Dr. Hilla Sheriff of the State Board of Health subsequently appeared before the Medical Association's Council on October 18, 1961. The following recommendations were made to the Council at this time:

1. Education—
   (a) Medical profession — through panels, exhibits, educational materials, and professional speakers at local and state medical meetings.
   (b) General public—through the usual means of communications such as TV, professionally prepared movies, newspaper releases, etc.
2. Cooperation with interested organizations such as
   (a) S. C. Highway Department
   (b) S. C. Industrial Commission
   (c) Civil Defense
   (d) Interested organizations including insurance companies
3. Advisory Committee to the Maternal and Child Health Division, S. C. State Board of Health on its accident prevention program.
4. Legislation—this committee should have the responsibility of developing and recommending accident prevention legislation to the Legislative Committee of the state Medical Association.

Council took the recommendations of the Accident Prevention Committee under advisement and the chairman was subsequently notified on October 24, 1961 by letter that:

"Council recommends to the House of Delegates that the Committee on Accident Prevention be made a permanent committee of the Association; that this committee be composed of seven members as follows: (a) The Chairman of the Committee on Accident Prevention of the S. C. Chapter of the American Academy of Pediatrics; (b) Six other members of the committee, two appointed for a one year term, two appointed for a two year term, and two for a three year term, with subsequent appointments for three years; that the function of this committee be to make recommendations in the spheres of education both to the medical profession and to the general public; cooperation after consultation with Council with the S. C. Highway Department, the S. C. Industrial Commission, Civilian Defense, and the Health Insurance Council; cooperation with the Advisory Committee to the Maternal and Child Health Division of the S. C. State Board of Health in its accident prevention program, and the development and recommendation, after approval by Council, of accident prevention legislation to the State Legislative Committee of the S. C. Medical Association; all activities of this committee to be subject to the approval of Council before action might be taken in any of the spheres of its activity.

"Council further authorized the present committee to function in this capacity, subject to approval of Council before action may be taken, until the next meeting of the House of Delegates."

Inasmuch as this committee has been mired down in a valley of indecision from lack of official status, etc., the committee chairman has avoided any involvement of the committee in controversial matters such as news media accident prevention spot announcements, etc. However, our efforts have not been completely absent inasmuch as we have attempted to further the accident prevention program mainly in working toward the education of the medical profession. Dr. Casper Wiggins of the Academy of Pediatrics Accident Prevention Committee and Dr. Hilla Sheriff, Child Health Division, State Board of Health, have cooperated in procuring certain exhibits which are planned to be shown to the medical profession at the annual meeting. Educational material procured will consist of four accident prevention movies which will be shown periodically during the breaks in a scientific meeting or at the beginning or end of scientific sessions of our state Medical Association. The following sound movies have been procured and will be shown repeatedly in the projection room set aside by the state Medical Association's Councilor:

1. "Accidents Don't Just Happen" — Time 13½ minutes
2. "One Days Poison" — Time 30 minutes
3. "Rescue Breathing" — Time 22 minutes
4. "Crash Research" — Time 10 minutes

In addition to the film showings an exhibit on seat belts will be prominently displayed in the hotel lobby and it is hoped that all physicians will take the time to go by and thoroughly study this very timely and valuable exhibit.

Finally, through efforts of Dr. Casper Wiggins of the committee, a prominent speaker on accident prevention will be presented in our state program. It is hoped that all physicians will take time to listen to this valuable contribution to accident prevention work. If our physicians develop a real interest in the prevention of accidents, some progress will have been made.

Henry W. Moore, M. D., Chairman

Coroner-Medical Examiners Systems Committee

The committee on Coroner-Medical Examiner Systems has met during this past year and discussed the problem of medical-legal investigations of death occurring within South Carolina in considerable detail. In the present coroner's system it was found that there was a definite need for adequate statistical information on the number of deaths of medical—legal importance which occurred within the state each year and the results of the investigations of these deaths. While the coroner of each county makes an annual report, this report is often difficult to obtain and it is therefore felt that some central agency should collect this information. The coroners of South Carolina do not have a clear cut delineation of their duties in regard to types of cases for investigation. This could well be remedied by the passage through the Legislature of an act defining the conditions under which post-mortem examinations may be made. The coroner also has difficulty in post-mortem examinations in that the fee set by law for the physician performing this procedure is entirely inadequate. Provisions for a more realistic autopsy fee should be made.

In the state of South Carolina at the present time there is no laboratory equipped to perform those determinations of medical-legal importance such as would be required for proper investigation. Some of this work for the coroner is done at Clemson College but provisions for proper equipment are not made. In Columbia the SLED laboratory can do some of this work and in Charleston at the Medical College there are facilities for toxicological analysis including trained personnel although no formal laboratory for this purpose has been established. The need for a laboratory of this type, properly equipped and properly staffed is paramount. Such a laboratory would be valuable under the present coroners system and would be readily transferrable if a system of Medical Examiners should be inaugurated in the future. This laboratory could also be of value to the Health Department for measuring exposure of workers to noxious chemicals in industry and for other problems in industrial toxicology.

The location of this laboratory could be somewhat of a problem because while the Medical College has the facilities and personnel which could be utilized and could perform an excellent service, the lack of a central location would decrease the value of the

laboratory unless a subsidiary laboratory could be established on the other side of the state in order that perishable specimens be adequately examined. A central laboratory placed in Columbia could be easily accessible to the entire state and such a facility could be operated in conjunction with the Medical College even though separated physically from it. Space could possibly be available in existing institutions such as the laboratory building of the State Hospital.

While it is the consensus of the committee that the present coroner system is inadequate because coroners lack knowledge and training in the investigation of deaths occurring within their jurisdiction, it is also the opinion of the committee that the problems of instituting a complete Medical Examiner System such as exists in Maryland or in Virginia would be great because of the cost and the scarcity of trained personnel. Because of this it was felt that improvement of the present set-up and further study of the problem could be of considerable benefit.

The committee recommends that a central laboratory for medical legal investigation and including provision for industrial toxicology be established by the State of South Carolina under an independent board to be appointed by the Governor and this facility be competently staffed and provided with equipment and space adequate to serve its purpose. An affiliation with the Medical College would be desirable whether or not the laboratory is physically connected with the institution. It is also recommended that statistical analyses of the coroners reports be made within the State of South Carolina, that the statutory fee for autopsy examinations for the coroner be raised to a proper level and finally that a model post-mortem examination act be submitted to the state legislature for passage.

Respectfully submitted,
E. A. Dreskin, M. D., Chairman
D. Strother Pope, M. D.
J. I. Converse, M. D.
C. Tucker Weston, Jr., M. D.
Robert P. Walton, M. D.

American Medical Education Foundation

Your A.M.E.F. Committee is pleased to report that we have this year again increased in the number of contributors to a total of 726 who have contributed to the foundation a total of $7,355.00. Seven hundred of the contributions, totaling $7,080.00, were made to the Medical College of S. C. In addition to this, $2,500.00 was contributed by the S. C. Medical Association and we have this day sent to the Medical College checks totaling $35,136.00. The remaining contributions were made by the various medical auxiliary units and by the faculty members of the Medical College. Approximately $24,000.00 was contributed by the faculty members. This amount of money was turned over to the President of the Medical College.

As in the past it will be used for purposes of medical education which have not been included in the budget. Such needs as additional salaries for the faculty and technicians usually consumes one half of the amount contributed. Approximately one fourth is used for students' benefits and the balance used for traveling, supplies and much needed equipment. This money is of great importance to the institution especially since they allow the President to handle unanticipated emergencies for which no budgetary provisions have been made.

This committee is particularly anxious to again impress on the members of the state Association that all monies contributed through A.M.E.F. go directly to the institution so designated by the contributor. The individual contribution may seem of little importance, but when the total amounts given are presented to others, such as the Association of American Manufacturers or to Industrial Associations, it has a very telling effect on their willingness to contribute to American Medical Education. It is well to remind the average physician of S. C. that the faculty of our medical schools generally contributes ten times the amount given by all of the physicians of our state. Total figures for the year are not available at this time, but will be given in a supplementary report at the State Medical Meeting.

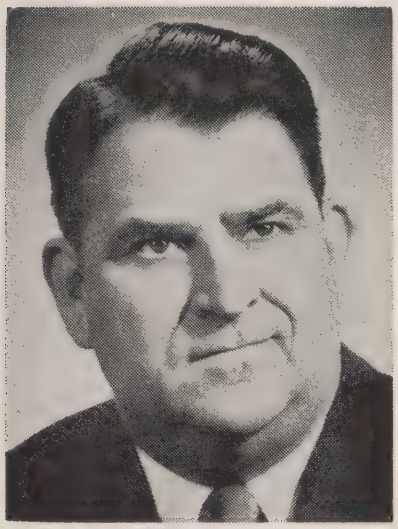
It should be re-emphasized that no restriction is put on the use of these funds except that they be over and above the budgeted program of the school to be used where otherwise no adequate funds would be obtainable. It is heartening to the committee that in the last several years the A.M.E.F. has enjoyed a substantial increase in the number who gave as well as the amount contributed. This great response is the product of a growing understanding of financial needs of our medical schools.

Respectfully submitted,
J. Howard Stokes, M. D., Chairman
Vince Moseley, M. D.
Thomas Gaines, M. D.

Committee on Medical and Hospital Insurance Contracts

The Insurance Program of the South Carolina Medical Association is progressing well. We now have fairly complete coverage of insurance. Because these types of insurance are different and because we have accepted only those we consider to be the best policy offered in each field, they are of necessity written and serviced by different companies through the State.

Our *Sickness and Disability Insurance*, written through the Educators Mutual Life Insurance Company, and serviced by Mr. Charles Dudley, 236 Ashley Court, Florence, S. C. has had a very satisfactory experience during its 5 year period, with a resulting decrease in premium. All members who hold policies with this company have recently received a refund on their last premium. In addition to this, the company has increased its limits so that we may now buy a maximum of $150.00 a week, instead of the previous high of $100.00.



DR. JOSEPH P. CAIN, JR.
DELEGATE TO THE AMA

The *Group Life Insurance Program,* written by Home Security Life Insurance Company, of Durham, N. C., and serviced by Talbert-Stubblefield, P. O. Box 469, Florence, S. C. offers term life insurance at a minimum cost. At the present time a drive is underway to enroll more members in this plan. We hope that the members of the Association will participate in sufficient numbers so that it will be a strong link in our chain of insurance. These individual certificates are non-cancellable.

High Limit Death and Dismemberment Policy, previously written by Columbia Casualty Company, with limits up to $250,000, was cancelled out on March 1, 1962 because of poor experience by the company—not with our particular group, but on the overall number of its policyholders. No company writes a policy with the limits and provisions this policy had. In its place we have a similar policy issued through the Royal Globe Insurance Company, with Mr. John M. Sadler, P. O. Box 5244, Columbia, S. C., as the broker. This company will write insurance up to $100,000 per person and pays total amount for death or double dismemberment, vision, or any combination, or half for single dismemberment or loss of vision; also, pays on a monthly basis for total disability pro-rata with the total, equals to the face amount. Aviation hazards for passengers are covered in all types of private and commercial—except certain types of military and experimental aircraft. The premium on this policy is 78c, as compared to 85c per thousand for the one that was cancelled out.

Office Overhead Expense, written by North American Insurance Company, serviced by John Cappelman Insurance Agency, Charleston, S. C., is available in a very attractive policy to pay office expense when the physician is sick and disabled. This premium can be deducted as a business expense.

We also have *Retirement Income Plan,* written by Minnesota Mutual Life Insurance Company, and serviced by Edwin M. Brooks, of Florence, S. C., which is the most liberal retirement plan available through life insurance companies today. While this plan will be more attractive when Bills such as Reed-Keogh, etc. are finally passed, it still offers a fine opportunity for an individual physician to invest in a policy of this kind if he so desires.

This is a very comprehensive program in insurance which the Association is offering to its members, and our Committee would like to point out the advisability of participation in these plans by as many members as possible. Since none of these policies will be cancelled individually, the more members enrolled in any one plan, the stronger this plan will be. The entire group can be cancelled on any anniversary date (the exception is the life policy, which is non-cancellable). It should be plain therefore that the more members enrolled the stronger the group, and the less likelihood it will be cancelled.

Please support your Association's program.

Kenneth G. Lawrence, M. D.
Clay W. Evatt, M. D.
Joseph P. Cain, Jr., M. D.,
Chairman

Committee on Disaster Medical Care

This committee consists of five members serving terms as indicated below:

Dr. William C. Herbert, Jr.—One Year Term
Spartanburg, S. C.
Dr. Charles R. May—Two Year Term
Bennettsville, S. C.
Dr. J. Graham Shaw—Three Year Term
Columbia, S. C.
Dr. Robert S. Solomon—Four Year Term
Moncks Corner, S. C.
Dr. Raymond Ackerman—Five Year Term
Bethune, S. C.

The committee has met on only two occasions since its appointment; May 31, 1961, and November 29, 1961. However, these two meetings did not reflect the several attempts to meet more often.

1. A resume of the May 31 meetings are as follows:

a. Raymond Ackerman was elected chairman of the committee.

b. A. A. Bushouse was elected as acting secretary of the committee.

c. As ex-officio member, Dr. Weston reviewed past activities of a like organization.

d. Dr. Ackerman reviewed the report of Dr. Weston which was presented to the House of Delegates at the 1961 convention.

e. The committee recommended that the Medical College of South Carolina at Charleston consider accepting an Abbreviated Training Unit of the 200 bed Civil Defense Emergency Hospital, in order to broaden the medical training.

f. The committee recommended that each credited hospital hold as one of its two annual dis-

aster rehearsals, one with each local Civil Defense Agency and its survival resources.

g. The committee recommended that members, and other interested persons, speak to County Medical Societies during their scheduled meetings.

2. A resume of the November 29 meetings are as follows:

a. The committee recommended a blood typing immunization program be initiated and continued throughout the state.

b. The committee recommended that construction of medical facilities with Hill-Burton funds include shelters, in addition to expanded medical treatment capabilities.

c. The committee recommended that a State-Line Training Course be scheduled in South Carolina. This is an abbreviated and condensed version of a National Health Mobilization Training Course and is designed to stimulate interest and participation of all professional and allied health personnel and lay people.

Maternal Health Committee

Analysis of S. C. Maternal Deaths — 1959

Hemorrhage:		14 (36%)
Cereberal	3	
Postpartum atony	4	
Abortion	3	
Abruptio placentae	2	
Placenta previa	1	
Retained placenta	1	
Toxemia:		11 (28%)
Eclampsia	6	
HVD	4	
Pyelonephritis	1	
Embolism:	7	
Infection:	5	
Pulmonary Edema:	1	
Sickle Cell Disease:	1	
Cardiac	1	
Acute Hemolytic Anemia with Tubular Necrosis:	1	
Indeterminate:	4	
Total	45	

E. J. Dennis, M. D., Chairman

Benevolence Fund

Directors:

W. Atmar Smith, M. D., Chairman
O. B. Mayer, M. D.
Thomas S. Goldsmith, M. D.

For the most part of the year, 1961, the Benevolence Fund has contributed substantially to the assistance of two elderly doctors, both of whom, during their active medical careers, had excellent records of service in their respective communities. Due to the aging processes and concomitant disease both of them were unable to provide for themselves and were compelled to accept financial assistance from others. The gratuities allotted by the directors had added much to their comfort. One of these physicians died



DR. GEORGE D. JOHNSON
DELEGATE TO THE AMA

in December and the other is still receiving help from the fund. During the year an appeal was made from the daughter of the physician and a contribution was made by the fund to assist her over a rough spot.

The various chapters of the Woman's Auxiliary of the State Medical Association have evidenced a keen interest in the purposes and plans set forth in an establishment of the Benevolence Fund. They have not only made a substantial contribution to the fund, but have been of assistance to the direcors in obtaining data concerning the eligibility and needs of those entitled to assistance. The following financial statement of the executive secretary of the Association indicates their interest.

FINANCIAL STATEMENT
BENEVOLENCE FUND
1961

Amount on Hand— January 1, 1961		$ 800.00
RECEIPTS		
Appropriated by Council for 1961	1000.00	
Feb. 17, 1961—Sumter County Women's Auxiliary	10.00	
Mar. 2, 1961—Anderson County Women's Auxiliary	20.00	
Mar. 8, 1961—Lancaster County Women's Auxiliary	10.00	
Mar. 16, 1961—Richland County Women's Auxiliary	25.00	
Mar. 21, 1961—Pee Dee Medical Auxiliary	25.00	
Apr. 14, 1961—Greenwood- Abbeville Medical Auxiliary	10.00	
Apr. 17, 1961—Newberry County Medical Auxiliary	5.00	
Apr. 21, 1961—Charleston County Women's Auxiliary	75.00	

Apr. 26, 1961—Ex. Committee—S. C. Women's Auxiliary	100.00	
May 16, 1961—S. C. Trudeau Society	100.00	
May 22, 1961—Greenville County Medical Auxiliary	150.00	
Total Receipts		1530.00
		$2330.00

DISBURSEMENTS

First Beneficiary		
Jan. 30, 1961	75.00	
Feb. 28, 1961	75.00	
Mar. 31, 1961	75.00	
Apr. 30, 1961	75.00	
May 31, 1961	75.00	
June 23, 1961	75.00	
July 31, 1961	75.00	
Aug. 29, 1961	75.00	
Sept. 30, 1961	75.00	
Oct. 31, 1961	75.00	
Second Beneficiary		
June 2, 1961	75.00	
June 23, 1961	75.00	
July 31, 1961	75.00	
Aug. 29, 1961	75.00	
Sept. 30, 1961	75.00	
Oct. 31, 1961	75.00	
Nov. 31, 1961	75.00	
Dec. 31, 1961	75.00	
Third Beneficiary		
May 25, 1961	65.00	
Total Disbursements		$1415.00
BALANCE ON HAND— DECEMBER 31, 1961		$ 915.00

In February of 1962 an application for assistance to the widow of a physician who also happens to be a daughter of a physician has come through a member of the Benevolence Committee of one of the chapters of the Women's Auxiliary. The directors have been investigating her needs and have alloted $100.00 per month for this very worthy beneficiary. The first payment was made in March.

Already this year contributions have come in from two auxiliaries. The treasurer of the Anderson County Society stated it was a "Doctor's Day Contribution" to the Benevolence Fund. The directors feel that this would be a splendid idea for the members of the auxiliaries to exploit. There is some uncertainty in the mind of the writer whether this is a suitable word, but it conveys the idea that it might be a good occasion to stir up interest in this project. The following is a report of the present status of the Benevolence Fund on March 10, 1962.

FINANCIAL STATEMENT
BENEVOLENCE FUND
1962

BALANCE ON HAND— January 1, 1962		$ 915.00
RECEIPTS		
Appropriated by Association, October 18, 1961	1000.00	
Barnwell County Medical Society	50.00	
Anderson County Medical Auxiliary	50.00	
Total Receipts		1100.00
		$2015.00

DISBURSEMENTS

First Beneficiary—		
January 31, 1962	75.00	
February 28, 1962	75.00	
Second Beneficiary—		
March 15, 1962	100.00	
Total Disbursements		250.00
BALANCE ON HAND— MARCH 15, 1962		$1765.00

March 13, 1962

Committee on Rural Health

The Rural Health Committee has held only one formal meeting this year. An exchange of ideas and material between committee members has been carried on by mail.

The consensus of this Committee is that it should function in an advisory or consultation capacity with other agencies in the rural health field.

We feel that doctors and nurses should be willing to serve on health committees of the various agencies and make talks to these groups, promote immunization and a program of accident prevention among rural people to help combat the hazards of mechanized farming.

In our opinion it is most important to maintain good public relations with rural people and to enlist their support in our fight against socialized medicine or any form of socialization. To this end we should promote a voluntary health insurance drive among the farm group.

Respectfully submitted,
A. R. Johnston, M. D., Chairman
Harold S. Gilmore, M. D.
Hugh W. Mole, M. D.
Swift C. Black, M. D.
Wm. J. Bannen, Jr., M. D.

THE EXECUTIVE COMMITTEE OF THE SOUTH CAROLINA STATE BOARD OF HEALTH

SUBMITTED BY
W. R. WALLACE, M. D., CHAIRMAN
(For Calendar Year 1961)

The membership of the Executive Committee has continued with no changes during the year, and with the following membership: Dr. W. R. Wallace, Chairman; Dr. Frank C. Owens, Vice-Chairman; Doctors E. W. Camp, Jr., R. W. Hanckel, W. Wyman King, Keitt H. Smith, J. Howard Stokes representing the South Carolina Medical Association; Dr. L. W. Busbee, the South Carolina Dental Association; Miss Ruth Chamberlin, the South Carolina Nurses Association; Ray G. Whitlock, the South Carolina Pharmaceutical Association; Attorney General Daniel R. McLeod; and Comptroller General E. C. Rhodes. Dr. G. S. T. Peeples has continued to serve as Secretary and State Health Officer.

The Committee met eleven times during the year 1961, and the following are among actions it took for the benefit of the public health in South Carolina:

Approved the location of one physician repaying his scholarship obligation at Berea and one at Winnsboro, and disapproved the location of one at Rock Hill, which the Committee deemed not a rural area, as previously defined.

Approved the sexual sterilization of three patients of State institutions (Whitten Village and State Hospital).

Approved recommended changes in the regulations governing the filing of birth and death certificates with the Bureau of Vital Statistics.

Approved changes in the nursing classification and compensation plan.

Approved recommendations concerning the crippled children's program, as follows:

Changes in the fee schedule for physicians participating on the program;

A proposed rheumatic fever clinic for Spartanburg;

The selection of Dr. Weston Cook to replace Dr. W. A. Boyd, deceased, as orthopedic surgeon;

The addition of an anesthesiologist and a physician qualified in heart surgery to the Crippled Children's Technical Advisory Committee;

Accepted a $1,000 bequest to the South Carolina Convalescent Home for Crippled Children by the late Mr. F. W. McKerrall of Marion, S. C.

Approved the proposed participation of the State Board of Health with the Cornell Research Group in a study of automotive crash injuries.

Approved the opening of a clinic for the mentally retarded preschool child in Columbia.

Approved the budgeting and expenditure of a special $25,000 appropriation to the State Board of Health for patrolling shellfish areas. (Heretofore all shellfish patrolling has been done by the commercial Board of Fisheries).

Approved changes in the rules and regulations governing milk and milk products, in order to make them more nearly conform to the Milk Ordinance and Code as recommended by the U. S. Public Health Service.

Approved regulations regarding polluted oyster replanting control procedures.

Revoked the license of one South Carolina nursing home, on recommendation of the Hospital Advisory Council, and took action on a number of other recommendations of this Council, reported elsewhere in this narrative.

DISEASE CONTROL

Influenza: Diseases that occurred of particular interest during 1961 were influenza, hepatitis, and poliomyelitis. There was an increased incidence of influenza in the early part of 1961 which was largely due to the Type A virus, as discovered by the relatively few isolations made. (Again, in the early part of 1962, there was a spotted distribution of local outbreaks involving largely school-age children and adults and which was discovered to be due to the Type B virus. This is the same type of virus that occurred in all parts of the country between November, 1961, and February, 1962. There were occasional cases of encephalitis following the 1962 influenza with some deaths in otherwise apparently healthy young adults.) A considerable number of cases of adenoviruses are being discovered also by the Laboratory.

Hepatitis: Hepatitis showed an almost three-fold increase from 1960 to 1961. It was generally state-wide, but localized outbreaks did occur. Surveillance of reported cases over 20 years of age did not reveal any specific source other than possibly personal contact. There was no evidence of association of any of the cases in South Carolina with consumption of raw oysters or clams.

Poliomyelitis: The interesting feature of poliomyelitis in 1961 was that of the 34 cases in the State, 22 of them were in Newberry County. In the Newberry outbreak the age distribution was atypical for South Carolina in that it occurred chiefly in the elementary school age group. Nineteen of the 22 cases were in Negroes, 13 of whom had had no vaccine and only one had had three or more doses. Of interest in this outbreak was that since it was due to Type III virus, Type III oral vaccine was used to control the outbreak.

This vaccine was obtained from Dr. Sabin himself from his individual supply. Through an excellent community effort, including 100% endorsement of this program by the County Medical Society, 21,200 of Newberry's 29,460 population received the vaccine on October 19, 1961. Ninety-one per cent of the population under 40 years of age received the vaccine and 41% of that over 40. (On February 8, 1962, Type I oral vaccine was given to 20,776 of the individuals who had received Type III). This vaccine was given on sugar at ten feeding stations throughout the county. The presence of an epidemic served as a motive for a good response to the first feeding but it was most gratifying to find that the majority of the

individuals returned for the second feeding without this motive. This type of mass program requires a great amount of total community effort and particularly the approval and support of the medical profession in the county. This is the first county-wide effort at giving oral vaccine in this county and the first time it has been attempted in a predominantly rural area.

Other Diseases: Other acute diseases occurred at relatively low incidence. Only 23 cases of diphtheria, 8 cases of typhoid fever, 13 cases of meningococcal meningitis and one case of anthrax was reported.

Rabies: Also of particular interest is that after ten years of rabies control program, not a single laboratory-confirmed case of rabies in any animal was discovered in 1961. This is a tribute to the Veterinary Public Health Section for good, long-term program planning and excellent cooperation of the county health departments throughout the State.

Nursing Care: The improvement of nursing care in nursing homes continued to be an important feature of the Chronic Illness Program. Two nurses and a dietary consultant were added to the staff of the Division of Disease Control in 1961 and have been concentrating on improvement of nursing care and food service in the nursing homes of the State. Almost 100 aides have been given a course in care of the nursing home patient, and in each of these homes the dietary consultant has worked with the food service personnel to improve diets.

Vector Control: The Vector Control Program continued with work being done in all 46 counties. Charleston County embarked on a Mosquito Control District Program in 1961 which is expected to fill a great need and serve as a demonstration for other such districts in the State.

Cancer: There has been a continuation of the routine services for early diagnosis, prompt treatment and long-term follow-up of patients cared for through the Sections of Cancer, Heart Disease, and Tuberculosis Control.

The encouraging gains made in the control of cancer tend to be overshadowed by the still heavy death toll taken by the disease. Much has been accomplished in this State in lengthening the life of cancer patients both in the state-aid Cancer Clinics and in private patients due to early case-finding. Fifty-five per cent of the private patients reported and forty per cent of the clinic patients had early lesions, a major factor in the cure and the control of cancer. A five-year survival and end-result summary was completed on all private and clinic cases reported with special emphasis on follow-up.

Heart Disease: It was encouraging that only three cases of luetic heart disease were seen in the heart clinics during the year, as syphilitic heart disease is preventable by the prompt treatment of early syphilis.

Recurrent attacks of rheumatic fever are being prevented by the use of antistreptococcal drugs, and more and more frequently private physicians are requesting prophylactic drugs from the Section of Heart Disease Control for their indigent patients. Cardiac surgery for incapacitating rheumatic heart disease is increasing. Through these surgical procedures most of the patients are so improved they can re-enter employment.

The intensive educational and informational project begun in 1960 is still under way in the Piedmont area and an evaluation of this survey should be of value to everyone concerned with public information and communication.

Commendable progress is continuing on the special project relative to epidemiological studies in cardiovascular disease in Charleston County through review of death certificates and a random population clinical survey with the heartmobile to collect data on some of the complications of arteriosclerosis.

Tuberculosis: In March, 1961, the Section of Tuberculosis Control in cooperation with local health departments and the U. S. Public Health Service began a project aimed at the elimination of tuberculosis as a public health problem in Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, and Jasper Counties. Additional counties, including Darlington, Florence, Georgetown, Horry, and Williamsburg, were added to the project area on July 1, 1961. Services are extended to tuberculosis patients and their families so that active cases may receive prompt hospital and out-patient therapy. Efforts have been made to bring contacts of newly discovered active tuberculosis patients to early examination, follow-up, and treatment as needed. Also, prophylactic treatment with INH for one year is being provided for infants under one year who are reactors to tuberculin and for children from one to three years who have, in addition, x-ray evidence of primary tuberculosis.

Venereal Disease: (a) The Problem: There was more *early infectious* syphilis reported in South Carolina during the calendar year 1961 than any other year during the past decade. Of the 644 cases reported, 235 occurred in persons of less than 20 years of age, representing 36.3% of the total. During the same period 10,558 cases of gonnorhea were reported; 2,232 or 21.1% were teenagers. The major problem areas in the State during this report period were Charleston, Greenville, Greenwood, and Richland. This would mean that these two venereal diseases may well be considered one of the most important public health considerations in South Carolina.

(b) Program Activities: Since more than two-thirds of all venereal disease case reports received by the State Board of Health came from private physicians, a good portion of program activities are directed toward a cooperative effort with private physicians. During the last year approximately 1,500 visits were made to private physicians' offices to acquaint physicians with services available to them from the health department. These services include darkfield microscopy, epidemiologic services, and distribution of current literature relating to the venereal disease problem. Approximately 1,100 books entitled *Syphilis, Modern Diagnosis and Management* were hand-delivered to private practitioners. Repre-

sentatives from the Section of Venereal Disease Control have met with local medical societies to discuss current venereal disease problems.

(c) Military: Close working relationship with the medical authorities at military bases in South Carolina is maintained. Representatives from the Venereal Disease Control Section are in attendance at most of the armed forces disciplinary meetings. Epidemiologic services in connection with early syphilis cases reported are available to all military areas in the State.

A program with the National Guard units was begun in October of 1961 and completed in February, 1962, thus providing a one-hour instruction course to each of the over one hundred National Guard units. This instruction included a short report on the venereal disease problem in this State and an educational film on venereal disease. This entire program was conducted by VD personnel on their own time—that is, after working hours and on Sundays.

(d) Clinics, Hospitals, and Institutions: The same services are available to clinics, hospitals, and institutions as have been outlined for the military and private physicians.

(e) Education: The Venereal Disease Consultant Nurse assisted by the Venereal Disease Contact Investigators promotes educational programs in schools, college, and universities, and schools of nursing. During the past year they have enlisted the support of the South Carolina National Guard as before mentioned, Christian Action Council, several medical societies and ministerial associations to help in promoting educational campaigns.

In-service training included a seminar on venereal diseases conducted by the Public Health Service in Dallas, Texas, February 28 - March 3, 1961, and a Venereal Disease Seminar for S. C. public health personnel was conducted in Columbia in December, 1961. Refresher courses in interviewing were held utilizing the closed circuit television set and tape recorders as teaching tools. Periodic staff meetings were held to keep the staff informed as to current trends, problems, and objectives.

New employees received courses in interviewing, darkfield microscopy, and orientation conducted for state employees.

Two recommendations made by the Venereal Disease Control Section of the State Board of Health were approved by the Executive Committee for the purpose of legislative action. The first of these was to amend one of the statutes so that private physicians would be allowed to report venereal disease cases by name. The second was a bill to require all laboratories, private and otherwise, to report their positive serologic findings to the State Board of Health. The Section Chief was accordingly authorized to present these two recommendations in proper form to the state Legislature.

LOCAL HEALTH SERVICES

County Health Departments: During the past year the Division of Local Health Services has discharged its responsibility of assisting county departments in developing and carrying on a well-balanced program of activities which included all the objectives of the state-wide public health program and, in addition, those objectives that were needed to meet specific local health needs. Service was rendered in the allocation of state and federal funds to the individual counties in keeping with the provisions of Appropriations Acts, assisting each county in the preparation and administration of its annual budget, and in justifying and securing local appropriations. Counties are kept informed of new laws and regulations pertaining to health.

Training of Personnel: The Division of Local Health Services has helped with recruitment, orientation and training of personnel employed in the county health units. With the assistance of the Nursing and Sanitation staff, county public health nurses and sanitarians have been given guidance in their local program planning of nursing and sanitation services.

Quarterly meetings of all health officers and administrative assistants have been held to discuss problems which the health officers themselves feel the need of discussing in groups where broad objectives and policies can be developed and interpreted.

In-service training has been provided public health workers through workshops and conferences conducted by the various divisions of the central office and regularly scheduled district meetings.

Emergency Hospitals: As a result of the transfer of the Federal Office of Civil Defense Mobilization to the Department of Defense, the U. S. Public Health Service has been assigned the responsibility for all civil defense affairs pertaining to health mobilization. Likewise, the State Civil Defense Administration has transferred this responsibility at the state level to the State Board of Health. The result of this is that the 26 prepositioned civil defense emergency hospitals stored in South Carolina are to be placed under the custodial care of the health department in the county in which they are stored.

Medical Self-Help Program: Also, the Medical Self-Help Training Program which was developed by OCDM at the request of the American Medical Association is to be carried out through county health departments. The county health departments will be responsible for the control of the training kits and for promoting the teaching of the course in their respective counties. All of this activity will be carried on with the advice and assistance of the Committee on Emergency Care of the state Medical Association. Each Self-Help class will be under the sponsorship of a local physician whenever such sponsorship is obtainable.

South Carolina has received 80 training kits and is expected to teach at least 2,000 individuals by July 1, 1962. This will serve as a period of evaluation of the training course after which the course and possibly the training kit will be revised. Following this, the kits and training material will be produced on a large scale wth the hope and expectation that within the

next several years at least 50,000,000 Americans will attend one of these courses.

Shortage of Trained Personnel: One of the greatest needs is for sufficient funds to enable the State Board of Health to employ personnel with adequate training in public health (there is an acute shortage of trained public health workers) or to employ personnel with good basic education and then have the means of assisting them in securing public health training. No state training funds have been available since 1951. At the present time (March 1, 1962) nine counties are without health officers and are being served by administrative assistants who have been appointed to have administrative responsibilities for property, supplies, the signing of official communications, liaison with county delegations and with the public in matters concerned with public relations. The administrative assistants are under the guidance of the Director of Local Health Services. The remainder of the 35 local departments are served by 23 full-time health officers and five part-time health officers. Of these 23 full-time health officers, six are 70 or more years of age. There are eight bi-county units, one tri-county unit, and the remainder are single units. The tri-county unit is served by one full-time health officer. Each of the bi-county units has a full-time health officer, and the remainder are served by a single full-time health officer or a part-time health officer, exclusive of the nine which at the present time do not have the service of a health officer. The county staffs consist of approximately 205 public health nurses, 100 sanitarians, and 129 full-time clerks.

MATERNAL AND CHILD HEALTH

This Division has continued its efforts to promote better facilities and services for the health of all mothers and children in South Carolina. This has been done through a program of service and education.

Clinic Program: A total of 18,197 mothers received services at maternity medical clinics during 1961, and public health nurses visited 7,442 mothers before and after delivery.

There were 1,104 child health clinic sessions with 8,311 new patients registering for service and 15,838 patients returning for service. In addition to these clinic sessions, nursing conferences were held in every county and supplemented by nursing visits into the homes when indicated.

Assistance has also been given to the local health departments in arranging for medical examinations of children, preferably by the private physician, prior to the admission in school. Programs of parent education with emphasis on readiness for school and continuous medical supervision with appropriate immunizations for their children are promoted.

(a) Biologics: Besides continuing to furnish immunization materials for diphtheria, tetanus, whooping cough, smallpox and Schick testing, this Division has contributed a large amount of funds for polio immunization material. This material is furnished free to all county health departments for indigent patients. Silver nitrate ampules, in order to insure a safe strength, are furnished to midwives for use in the eyes of the newborn babies whom they deliver.

(b) Midwife Program: The number of midwives certified for practice has decreased from 746 in 1961 to 681 for 1962. The program of training, supervision, and control still requires a great deal of attention. This activity is carried out through annual institutes provided by this Division and monthly classes and direct supervision by the local health departments.

(c) Educational Program: A course in Child Growth and Development sponsored and financed by the Maternal and Child Health Division was offered at the University of South Carolina for three semester credits at its summer session in 1961. Nineteen public health nurses took this course. As a follow-up each nurse is expected to develop a project in her community relating to child growth and development.

Classes were expanded for expectant parents, using the discussion group techniques developed by the Child Study Association where several of our nurses have been trained.

This Division has continued to sponsor postgraduate education for physicians and nurses. Forty-one South Carolina physicians attended the Obstetric-Pediatric Seminar held in Florida, cooperatively planned and sponsored by the Maternal and Child Health Divisions of the state Health Departments and the state Medical Associations of Florida, Georgia, Alabama and South Carolina. This Seminar is accepted by the American Academy of General Practice for credit in Category I.

This Division assisted in securing speakers and in preparing scientific and educational exhibits for meetings of medical specialty groups and other professional and lay groups.

Two public health nurses have been assigned to the Richland County Health Department so as to meet some of the specific needs in relation to services to mothers and children and to improve teaching facilities so that the University of South Carolina nursing students will get better training and experience in giving public health nursing services to mothers and children. An additional nurse has also been provided by this Division to Beaufort County Health Department to assist in the work with mothers and children in that area. The special monthly clinics for maternity patients developed in cooperation with the Medical College of South Carolina have been expanded.

This Division has recommended that routine screening test for phenylketonuria be done at all well-child clinics over the State.

Staff members have continued to work with other agencies, organizations and institutions that have mutual goals, that is, better health for mothers and children. For further details concerning activities, please see Annual Report of the State Board of Health.

School Health Program: In an effort to further strengthen and expand school health services, several activities have taken place during this year. The School Health Committee of the South Carolina

Medical Association and this Division jointly sponsored a meeting of state and local school health committees of medical societies in March, 1961. Dr. Dukelow from the American Medical Association's Bureau of Health Education was the guest speaker and consultant. The aim of this meeting was to encourage joint planning and carrying out of local school health programs by school administrators, health department personnel, and private physicians depending upon area needs and facilities.

As a result of a course in School Health Nursing sponsored by this Division at the University of South Carolina at its summer session in June, 1960, various outstanding projects and programs have been instituted by the nurses who attended from 17 counties.

The vision screening program has been extended to include 23 counties. Volunteers trained by this Division's nursing staff screened 29,032 children during 1961. This program has engendered much community interest and has been the means of not only finding but also correcting many vision abnormalities.

The State Joint Health and Education Committee, of which the director and the pediatric consultant nurse are members, has been actively working on various standards and service programs for school health. These have included (1) Revisions of the Recommendations for School Health Service Unit with Suggested Plans; (2) Revision of School Health Record and Manual; (3) plans for a special survey on selected areas of the total school environment on the mental and physical health of children; (4) an analysis of Functions of the Nurse in the School Health Program.

Another activity that deserves mention has been the promotion of interest in nutrition education for high school students through the Science Fairs held in various parts of the State. Science teachers throughout the State have been sent suggestions for nutrition exhibits and a bibliography of resource materials in an effort to stimulate interest in this subject. We hope this will result in students going into human science fields such as nutrition—of which there is a great need in this State.

Mental Retardation Project: An evaluation clinic for children up to seven years of age who are or are suspected of being mentally retarded was opened in Columbia in April, 1961. Previously such a clinic operated in Charleston in cooperation with the Pediatric Department of the Medical College. This clinic is financed by an ear-marked appropriation by Congress through the U. S. Children's Bureau. The clinic accepts physician-referred patients from over the State. Its staff consists of a pediatrician, psychologist, social worker, public health nurse, and stenographer with provisions for consultation from other specialists. Follow-up care is given by the private physicians with desired assistance from local health department personnel. Cooperation with various organizations and institutions dealing with mentally retarded children is a strong part of this program. Community interest and activities are encouraged to further meet the needs of the retarded child who remains in his home.

Accident Prevention Program: Efforts have been continued to reduce the number of accidents, childhood's greatest killer. The two poison control centers, one in Columbia and one in Charleston, have continued to function. Reports are being forwarded to the National Clearing House for compilation in nationwide studies. Epidemiological investigation of cases by the local health department personnel has been a valuable basis for education in prevention.

The Accident Prevention Committees of both the S. C. Medical Association and the S. C. Chapter of the American Academy of Pediatrics have met jointly several times and have been most helpful in planning educational materials and plans of action toward the prevention of accidents. Because of the great concern over eye injuries, a questionnaire was formulated and mailed to all ophthalmologists in the State by this Division in cooperation with the S. C. Chapter of the American Academy of Pediatrics. As a result of the findings, it was recommended to the state Medical Association that legislation be enacted to forbid the sale or manufacturing of lead missiles or shots for any type of toy guns. A second legislative recommendation to the state Medical Association by its Accident Prevention Committee and this Division concerns the requirement of vision acuity tests on all renewal applications for driver's license.

A demonstration project on "Home Poisoning" for three years was initiated through this Division by the U. S. Public Health Service, Division of Accident Prevention. Cooperating in this project is the Charleston County Health Department, the Pediatric Department of the Medical College, and the Charleston Poison Control Center. Pediatric residents are assisting in this project by making talks to various parent groups. The objective of this study is to evaluate education through its many facets as a preventive agent for poisoning experienced in young children. Aspirin and kerosene are the leading ingestants.

This Division is acting as medical coordinator for a three-year automotive crash injury research project which was initiated in South Carolina in June, 1961. This project is sponsored by the State Board of Health, the S. C. Highway Patrol, the S. C. Medical Association, and the S. C. Hospital Association in collaboration with Cornell University. The basic purpose of this research is to gather data on the specific causes of injury to victims in passenger automobiles after the initial impact of the accident in order to provide definite information for future safety engineering in automobiles. Through December 31, 1961, a total of 210 cases were processed through this Division.

CRIPPLED CHILDREN

The Crippled Children's Division has continued its regular diagnostic and treatment services through its clinic, hospitalization, convalescent, and appliance programs.

Services Rendered: As of December 31, 1961, there were 5, 754 patients on the Crippled Children's Pro-

gram. During the calendar year 1961, a total of 4,226 patients made 11,794 clinic visits; 726 patients spent a total of 12,343 days in the hospital; 116 patients received a total of 11,625 convalescent home days; 159 patients were discharged as cured.

During the summer a two-week speech therapy course was held for cleft palate children in the Columbia district area in special need of concentrated speech therapy. Arrangements were made with the Carolina Children's Home to house these patients for a very nominal fee, and the Division paid the salary of a speech therapist to provide the therapy. It is hoped that a similar course may be held next summer, as the results seem very gratifying.

During the month of July, 175 children (91 white and 84 Negro) attended the two orthopedic camps made possible by special annual grants of the Legislature since 1948.

The program for congenital heart disease patients has continued to increase—182 children seen in 1960 and 313 seen during 1961. During 1961 there were 1,290 hospital care days provided for congenital heart cases.

A Rheumatic Fever Clinic center was opened in Spartanburg. The nurse from the Greenville Rheumatic Fever Clinic has the over-all nursing responsibility of the clinic. A full-time clerk has been employed for the new clinic, and also a part-time pediatrician and cardiologist.

Physical therapy is now available in Georgetown at no cost to Crippled Children's patients, through a cooperative effort of the South Carolina Crippled Children's Society.

Convalescent Home: The Convalescent Home has run at full capacity, having served a total of 116 patients. During the winter months there was a waiting list of five to six patients. The Director of the Department of Physical Medicine and Rehabilitation of the Medical College of South Carolina makes monthly visits to the Convalescent Home in a consultative capacity and makes rounds with the orthopedist in charge. Special arrangements were made this year to provide physical therapy on a fee basis through a local physical therapist. This has relieved the district nurse who is also a physical therapist and who had been giving physical therapy treatments to the Convalescent Home patients as her time permitted.

Additional Personnel and Equipment: During the year a second district nurse was added to each of the four orthopedic clinic centers. These nurses are proving very valuable in helping manage the increased case load, clinic attendance, and hospitalizations.

The Central Office of the Division was very fortunate in securing an additional medical social worker. The State has now been divided into two territories to be served by the two medical social workers on the staff. Actually there is a need for additional social workers, but lack of funds and scarcity of trained personnel make it difficult to recruit additional personnel.

For quite some time the Central Office has been desirous of making some changes in the over-all filing system. During the year, because of the extreme shortage of space, and the availability of money to use for the purpose, special financial record card equipment was purchased to make possible easier, quicker, more compact record keeping. Also a new system was purchased and installed for the filing of the case records on all active cases.

DENTAL HEALTH

Education: The Division strives to attain a goal in dental health education by making it possible for pupils and parents to appreciate good oral health and its relation to general health and appearance and to help the individual discover his dental problems and take action in solving them. This is done in many ways with various methods of approach.

In cooperation with the county health departments and the elementary schools, the "Little Jack" Mouth Health Show was shown to approximately 119,690 children in 370 schools. The show teaches the rules for good dental health and is most effective in favorably influencing dental health attitudes, knowledge and habits. Thousands of letters were written to "Little Jack" by school children who had seen the show, promising to practice the rules for good dental health. These letters were answered with a form letter containing additional mouth health information. "Little Jack's" monthly news sheet, known as "Jack's Tracks," was sent to every grade in the elementary schools, county health departments, county superintendents of education, dentists, and pediatricians.

National Children's Dental Health Week, in cooperation with the American Dental Association, the South Carolina Dental Association, and local dental societies, was observed February 5-11, 1961. This week is planned to focus attention on the seriousness of the dental health problem of our children and youth, and offers an opportunity for stock-taking in every community to discuss the dental needs of its children and plan for the development of programs to meet the problem. Fifty portfolios and a large number of the dental health week posters were distributed to key persons in the State. A memorandum from Dr. Jesse T. Anderson, State Superintendent of Education, was mailed to all South Carolina educators, asking their cooperation in the promotion of National Children's Dental Health Week. Spot announcements on dental health were used by radio and television stations during and after Dental Health Week.

Fluoridation: It was recommended and urged by the Division that fluoridation, where feasible, be adopted by all communities in the State having a public water supply. At the present time, there are eighteen communities in the State adjusting their public water supplies to the optimum level of 1.0 p. p. m. fluoride. The town of Clemson, population 18,000, began fluoridation in February, 1961. This decay-preventing measure has been made available to 183,700 persons in the State.

A free service to the dentists prescribing fluoride for patients was added to the dental health program during the year. This service is the analyses of drinking water for fluoride content. Any dentist in the State may send a four-ounce sample of a patient's drinking water to this office. The sample is analyzed, and the dentist requesting the analysis is notified of the results.

Demonstrations in the application of sodium fluoride to the surfaces of children's teeth in rural areas and in communities where public water supplies are not fluoridated were continued. A sodium fluoride mobile team, operating in a dental trailer furnished by the State Board of Health, travelled the State applying a 2% solution of fluoride topically to children's teeth. Through these demonstrations and the resulting locally sponsored programs, thousands of children receive these treatments every year. Permanent dental clinics were operated in Spartanburg and Richland Counties. Spartanburg reported 12,478 dental corrections and Richland County 11,820 corrections during the year.

Dental Survey: With surplus federal funds from the Nursing Home Program, the Division of Dental Health, in cooperation with the South Carolina Dental Association, conducted a dental survey for the aged in the nursing homes in the state. Approximately fifty dentists and all sixty (100%) of the licensed nursing homes participated in the survey. Oral examinations were performed on 1,606 patients. While no corrective work was done on the survey, it is hoped that the results of the survey will lead to corrective measures through some source in the federal, state, or local governments.

HOSPITAL CONSTRUCTION

Administration: In 1947 the General Assembly of South Carolina enacted the "State Hospital Construction Act" and designated the South Carolina State Board of Health as the responsible agent for the administration of the Hill-Burton Act and Hospital Licensure in South Carolina. The Hospital Construction Section is the organizational unit within the agency delegated the responsibility of administering the Hospital and Medical Facilities Construction and Licensing Programs. In accordance with the mentioned state and federal laws the Governor appointed a Hospital Advisory Council to consult and advise with the State Board of Health on all matters relating to the administration of the licensing and construction programs. This Council met five times during the 1960-1961 fiscal year, and its sub-committee for licensing had two meetings.

Medical Facilities: In the past 14 years (1947-1961) over $80 million has been spent towards the construction of medical facilities in this State. Of this amount $37.9 million has come from the Hill-Burton Act (Public Law 725 and Public Law 482 as amended). During this period the following medical facilities have been constructed with Hill-Burton assistance: twenty-four (24) completely new hospitals, seventy-six (76) hospital bed or adjunct facility additions, twenty-nine (29) main health centers, two (2) additions to health centers, fifty-eight (58) auxiliary health centers, three (3) nursing homes, eight (8) nurses' residences, four (4) nurses' residences and training schools, two (2) mental health clinics, and one (1) rehabilitation facility. These projects have provided 5,420 additional beds as well as new and improved facilities for the diagnosis, treatment, and care of patients and for teaching and training of personnel in the medical field.

The Executive Committee of the South Carolina State Board of Health on September 21, 1961, in consultation with the Hospital Advisory Council, set aside the following amounts of Hill-Burton funds (Public Law 725 as amended) for the construction of medical facilities for the fiscal year 1961-1962: general hospital and reserve construction funds, $3,493,334.93, and $220,000 for the construction of public health centers. The U. S. Public Health Service for the mentioned fiscal year authorized the state agency to allocate $1,236,220.00 to eligible applicants to pay part of the cost of constructing nursing homes, chronic disease facilities and diagnostic and treatment facilities. In addition the Congress authorized $160,249.00 for the construction of rehabilitation centers. While considerable progress has been made in the past 14 years, South Carolina still needs, according to Hill-Burton planning data, 3,720 general hospital beds, 4,414 chronic disease beds, 9,286 mental beds, 173 tuberculosis beds, and 5,954 nursing home beds. This State can now construct under the Hill-Burton Program 180 diagnostic and treatment centers, 9 main public health centers, 166 auxiliary public health centers, and 7 rehabilitation centers. The Community Health Services and Facilities Act of 1961 changed the definition of a rehabilitation center so that a project of this kind can now be approved if it provides medical evaluation services and one or more of the following services: psychological, social or vocational. Heretofore, it required that all such projects include all four of the designated services.

Nursing Homes: The Surgeon General of the U. S. Public Health Service approved the 1961-1962 Hill-Burton State Plan on September 28, 1961, which included a proviso setting forth that all projects that are to be placed under contract during the mentioned fiscal year would receive a federal share of 66-2/3%. Last year the federal share for Hill-Burton projects was 50%. The change in the federal share has stimulated the construction of much-needed medical facilities in South Carolina, particularly in the area of nursing homes. The State Board of Health and its active Hospital Advisory Council can now report that long-term care facilities (nursing homes) are now being planned for the Greer Unit of the Greenville General Hospital; Divine Saviour Hospital, York; Loris Community Hospital, Loris; Wallace Thomson Hospital, Union; and the Cherokee County Memorial Hospital, Gaffney. Hill-Burton nursing homes have already been constructed and placed in the following

counties: Greenville, Spartanburg, and Lancaster (Marion Sims Memorial Hospital).

Program for Aged Persons: Due to the implementation of the Medical Care Program for Medically Needy Aged Persons Act (Kerr-Mills) by the South Carolina Department of Public Welfare on July 1, 1961, and the enactment of the federal law entitled "Community Health Services and Facilities Act of 1961", the State Board of Health is spearheading an intensified program to improve the quality of care in nursing homes. The new Chronically Ill and Aged Program within the Agency is operating under the Division of Disease Control which consults and advises with the Hospital Construction Section on Licensing matters. The Hospital Construction Section is currently inspecting and licensing 103 hospitals, 61 nursing homes, and 13 related institutions. These institutions provide accommodations for 10,151 patients.

SANITARY ENGINEERING

Consultation Services: The Division of Sanitary Engineering is responsible for the administration of health programs from a state level and participates in other programs handled principally by the various counties throughout the State. One of the main functions of this Division in connection with county programs is to furnish, upon request, consultation services on public health problems. Our total efforts are directed toward a cooperative program embracing this Division and the various county health departments.

Specific Activities: This Division is divided into sections, each with specific responsibilities, including the administration of rules and regulations and laws governing activities which normally might be indicated by the section titles: Water Section; Sewage Section; Food Processing Section—Wholesale and Retail; Bedding Section; Milk, Shellfish, Bottling Plants, and Frozen Dessert Section.

In addition to the specific activities listed above, we are confronted with many public health problems which cut across all sections enumerated and impose other responsibilities upon the division—for instances, responsibilities in connection with the planning and development of subdivisions throughout the state; the consideration of public health implications in the proper planning of schoolhouse construction, motels, swimming pools, trailer parks, organized camps, etc.; industrial development and many other projects of similar connotation.

Space limits specific comments on individual programs. However, since the Shellfish Program has developed significantly since our last report, we will mention it. The Attorney General has ruled that the State Board of Health is responsible for the patrol of all shellfish-bearing waters. This imposes an added responsibility, and we have had to secure a deficiency appropriation to procure additional boats and personnel to discharge our obligations in this activity. Continuous surveillance of shellfish taken, for relaying, from polluted waters is a must since the U. S. Public Health Service has indicated the association of contaminated shellfish with outbreaks of infectious hepatitis. Such surveillance is the only way to prevent shellfish of questionable quality from getting into the commercial market. Our efforts will be directed to adequate protection of the public from contaminated shellfish.

Radiological Laboratory: The State Board of Health, in cooperation with the Water Pollution Control Authority, has developed an effective Radiological Laboratory designed to monitor the environment generally and to perform specific duties as may be indicated in connection with the utilization of radioactive material for any purpose throughout the State.

There is a strong liaison between the Engineering Division and the Water Pollution Control Authority. All matters of mutual interest are discussed in the light of common benefit, leading to an appropriate solution for the betterment of health conditions throughout the state.

Observation of the operation of this division indicates that additional personnel is needed to keep pace with the ever-expanding industrial picture in South Carolina and the attendant problems with explosive population increase.

LABORATORY

Laboratory activities of new or notable interest during 1961 included several in the parasitology, virology, and special bacteriological sections. Surveys for intestinal parasitic infection were carried out in numerous schools and in some smaller groups in the coastal plain area of the state. Predominantly in this area, 629 cases of necator americanus and 605 of ascaris lumbricoides infestation were found in examining 7,861 specimens. Conferences with health officers, county nurses, and teachers have aided in scheduling and carrying through these surveys.

In the virus laboratory, participation in the epidemiologic study of the Newberry County poliomyelitis outbreak in the fall of 1961 identified the poliovirus as Type III. Other viruses isolated during the year were Type I poliomyelitis in three cases; two Coxsackie types (B3 and B4); one case of ECHO 6, and several unidentified viruses which, after prolonged study in tissue cultures available here, were referred to the Communicable Disease Center. Viruses remaining unidentified after these steps have been taken are frozen at —70 degrees Centigrade for further investigation in the light of future knowledge. Considerable time has been allocated during the past year to the culture of different tissue cells for the purpose of enlarging our opportunities for virus isolation and identification.

In examining 403 animal brains for evidence of rabies in the Central Laboratory and 32 in the Charleston County Laboratory, no Negri bodies were found. In 51 of these, negative results were confirmed by mouse inoculation. In contrast, during 1960 there were 506 animal brains examined, with positive results in seventeen. Although the need for human anti-rabies vaccine immunization has diminished, as

indicated by these findings, doses of anti-rabies vaccine for 158 human treatments were sent out from the Laboratory upon request of county health directors and other physicians during the last six months of 1961, of which approximately 60% were duck embryo vaccine and the remainder Semple. The present availability of duck embryo anti-rabies vaccine, the feasibility of its administration in the now diminishing number of cases of human exposure, its prompt effect in antibody stimulation, and its relative safety (in contrast to the risk of neurologic complications in the use of Semple vaccine) have indicated the advisability of its use except in the rare cases giving evidence of allergy to this protein.

Expansion of the work in the fluorescent antibody section of the Laboratory has continued, 273 throat cultures received from sources in twelve counties having been examined during 1961 for identification of Group A beta hemolytic streptococci. A report on the results obtained, in examining 189 cultures received during the first 11 months of this study, was presented by the senior bacteriologist of the Laboratory at the Fluorescent Antibody Streptococcal Seminar held on November 10 at Denver, Colorado, showing the higher efficiency combined with specificity of the fluorescent antibody method as compared with the conventional culture method. The latter was less efficient in having demonstrated beta hemolytic streptococci other than Group A in 7 cases requiring differentiation by the time-consuming precipitin test and having failed to detect the presence of beta hemolytic streptococci in 5 cases in which these were identified by the more rapid fluorescent antibody technique. Further expansion of the work of this section of the laboratory is anticipated, to be used in the diagnosis of rabies, in fluorescent treponemal antibody identification and in virus identification.

In the section allocated to the study of acid fast organisms, 6,887 specimens were cultured by routine techniques, revealing 601 positive for typical Mycobacterium tuberculosis, and 313 were further investigated by subcultures and cytochemical tests, revealing 170 cases of infection with other (atypical or "unclassified") acid fast bacilli, as follows:

Group I (photochromogens)	11
Group II (scotochromogens)	36
Group III (non-photochromogens)	123

A significant increase in the number of cases in which these bacilli can be identified is noted with the addition of special procedures to routine techniques. Also in this laboratory section are carried out the mycology cultures for identification of pathogenic and potentially pathogenic fungi. In 1961 there were 155 of these cultures.

The Central Laboratory performed 318,582 tests and examinations, including 252,510 serum tests for syphilis. In this serology section a noteworthy occurrence was a visit made by a consultant from the Venereal Disease Laboratory of the Communicable Disease Center with whom current techniques were thoroughly discussed by members of our Laboratory staff.

Approximately 47,000 tests and examinations were carried out by the 4 district laboratories and the 4 county laboratories, including tests of milk and water samples, examination of slides and cultures for pathogenic bacteria, stool specimens for intestinal parasites and others. Participation in the packing and shipment of specimens being sent to the Central Laboratory for virus isolation, and the collection and preparation of other specimens for special procedures are also functions of these laboratories.

Seven members of the Laboratory staff attended courses which included the following subjects:

Fundamentals of Virology
Laboratory Methods in Medical Bacteriology
Laboratory Methods in Enteric Bacteriology
Tissue Culture
Laboratory Methods in the Diagnosis of Viral and Rickettsial Diseases
Laboratory Methods in the Diagnosis of Rabies
Fluorescent Antibody Streptococcal Seminar
Introduction to Fluorescent Antibody Methods
Equipment Service

PUBLIC HEALTH EDUCATION

Since progress in public health is dependent upon the understanding and cooperation of the public for whom services are offered, education is an integral part of public health programs; and the Health Education Section serves as the central coordinating body in directing educational and informational services of the State Board of Health.

With its objective of not only preventing death and disability but also encouraging better living through improvement of health practices, the Section offers services to assist the promotion of the varied health programs of the State Board of Health and local health departments. It prepares and distributes educational and informational materials, including audio-visual aids, provides consultation in methods and techniques of health education, and maintains close cooperation with other official and voluntary health agencies and civic and community groups concerned with public health activities.

During the year, the Section maintained a library of 415 health films and provided nearly 3,000 showings before more than 200,000 South Carolinians. More than 20 pieces of audio-visual equipment were provided on loan to various organizations each month, and 11 exhibits were provided for public display in county fairs and specialized meetings. Nearly 200 health programs were provided to radio stations, and numerous spot announcements were furnished to both radio and television outlets. The *Monthly Newsletter* was prepared and distributed to public health workers and other agencies and interested persons, and numerous news releases of public health interest were furnished periodically to the state's mass media outlets. Preparation, printing, and distribution of the *Annual Report* and revision of the *Public Health Laws Manual* and the *Records Manual* were also handled

by the Section in addition to organization and conduct of the orientation program for new employees and participation in the planning and conduct of various in-service programs.

In addition, personnel of the Health Education Section participated actively in many meetings, conferences, and seminars with other agencies, both official and voluntary, in moving toward the common goal of creating and maintaining improved public understanding of health practices and procedures and of stimulating the over-all improvement of these practices.

PERSONNEL OFFICE

During the past year a total of 1,294 personnel actions were prepared and processed by the Personnel Office. This represents an increase of 705 over the number of actions handled during the previous year. It is readily seen that we have had an extremely busy year, because each personnel action involves the additional handling of Budget and Control Board, Retirement and Social Security, pay roll, and Attendance and Leave records.

The past year also saw an increase in the total number of employees of the State Board of Health from 880 to 925. This increase of 45 new employees is attributed mostly to the increase in programs and services of the Maternal and Child Health, Crippled Children, and Disease Control (Nursing Home) Divisions. It should be noted that each new employee automatically increases every phase of the work in the Personnel Office, which means that the pressure of the work load in this office is always getting greater, yet we are still attempting to render service with the same staff (3), which we had eight years ago when our total number of employees was 300 less than it is now. There is a desperate need for the addition of at least two persons to the staff of the Personnel Office, and for more office space so that certain phases of this work which is highly confidential in nature could be carried on with more privacy and more adequate space allocated for the filing of pertinent records.

Two new group insurance plans offering our employees such protection as salary continuation during illness and a life insurance savings plan were installed during the past year. Five hundred fifty-six of our employees are participating under the four pay roll deduction insurance plans, and approximately 258 received benefit checks during the year.

Our Directory of Personnel, which lists the staff of all county health departments, divisions, and sections of the State Board of Health, was completely revised twice during the year. Also, six new class specifications were established under our Merit System position classification plan, and nine of our old class specifications were revised during the year.

VITAL STATISTICS

The population of the State of South Carolina is constantly increasing which, in turn, results in an ever-expanding program for registering births, deaths, fetal deaths, marriages and the supplemental documents necessary for correcting and amending the original documents filed. The department is currently registering and housing approximately 135,000 records annually, exclusive of the supplemental documents, which represents an increase of approximately 94% when compared with the vital records registered and housed in the department during the calendar year 1945. The demand for services by the public in general, the medical profession, public agencies, industries and various types of civic organizations continues to increase. Requests for statistical data have shown a substantial increase for the year 1961.

There has also been a substantial increase in the legal transactions involving the records of the department. For example, there were 1,489 certificates amended as a result of adoption. This is roughly four times the number of certificates amended as a result of adoption in 1945. In addition to certificates amended as a result of adoption, there were 702 certificates amended as a result of the mother marrying the father of the child after its birth (there was no provision for this type procedure in 1945), and 172 court orders, primarily representing changes in name. The department is also involved in a rather extensive program of filing delayed certificates of birth for those persons for whom no certificate was filed at time of birth and in correcting obvious errors in original certificates where the incorrect data was furnished at time of birth. This program involves the filing of approximately 6,500 delayed records and the correction of approximately 15,000 original records annually.

A Bill for filing divorce and annulment data with the Bureau of Vital Statistics was passed by the House of Representatives in 1961 and is currently in the Judiciary Committee of the Senate.

During the calendar year 1961, the Bureau of Vital Statistics participated in several special research projects, examples of which are: A special study with the U. S. Public Health Service on matched infant deaths; a study of neonatal and perinatal deaths by the South Carolina Medical Society's Committee on Infant and Child Health; a special study in Charleston County to determine the percentage of accuracy of age reporting on death certificates; and the Johns Hopkins University School of Hygiene and Public Health special study on radiation in connection with the deaths of physicians.

The overcrowded conditions existing in the Bureau of Vital Statistics was overcome during the latter part of 1961 when the department was moved to temporary quarters at 1321 Pendleton Street.

IN MEMORIAM

Each year when our South Carolina Medical Association meets there are a number who do not answer the roll call for they have answered the roll call eternal. Since last May, 48 of our members are no longer with us but they will certainly live for many years in the hearts of loyal patients and friends for whom they have been unselfish benefactors.

With unrelenting progression life hastens to its finale. Fond friendships that we have been privileged to share move everlastingly onward and only sacred memories remain to remind us of lives well spent.

It is not known whether this poem was written about doctors or not, but who else does it fit so well?

"Give me always a goal to try for,
Let me fight till my breath is spent;
Give me a dream to live and die for,
And I shall be content.
Keep for others your silken leisure,
Drowsy days in the shade or sun;
I was never one to treasure
Rest, till my work is done.
No, for sloth is the worst of sinning,
Give me the joy and the zest of the fray,
Finding true reward in the winning—
Not in the prize or pay."

"And if Victory be denied me
I shall not shrink from another test,
Nor care at all if my foes deride me,
Knowing I did my best.
Somewhere still there are roads uncharted;
Somewhere still is an unfound Grail;
Let me go onward, valiant-hearted,
To the end of the last long trail.
Give me always a goal to try for,
Let me fight, till my breath be spent;
Give me a dream to live and die for,
And I shall be content."

Boyd, W. A.
Breland, William H.
Browne, S. M.
Bryson, James L.
Byerly, William L., Jr.
Carnes, W. C.
Clinkscales, Grady S.
Corn, C. P.
Crosby, C. E.
Dibble, M. E.
Duke, W. R.
Fuller, L. S.
Gibson, W. T.
Green, S. R.
Harrell, Charles
Hood, E. C.
Hughston, G. F.
Hunter, James H.
Inabinet, Thaddeus J.
Judy, W. S.
Kredel, F. E.
Lancaster, Walter
Lemmon, Charles J.
Lind, S. C.
McLeod, George H.
McMaster, J. G.
Moore, E. H.
Moore, J. Clyde
Nelson, George K.
Newell, W. B., Sr.
O'Hear, James
Pearcy, Curtis
Pinner, Carroll
Ravenel, Leonard
Sharpe, W. W.
Simmons, E. A.
Smith, Josiah E.
Temples, P. M.
Todd, B. H.
Townsend, J. F.
Tripp, H. D.
Tuten, W. R.
Vaughan, Herbert E.
Wagener, Henry P.
Weinberg, Milton
Whitley, R. M.
Wilcox, Everard A.
Williams, H. B.



Exhibitors' Pages

SCHERING CORPORATION

You are cordially invited to visit the Schering technical exhibit where the following products will be featured: Chlor-Trimeton, unsurpassed antihistamine; Celestone, most active corticosteroid available; and Fulvicin and Advicin, the first combination to meet the requirements for successful athlete's foot therapy.

MEAD JOHNSON LABORATORIES

The Mead Johnson Laboratories exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

MERCK SHARP & DOHME

The theme of the Merck Sharp & Dohme exhibit is "SERVICE TO MEDICINE". One phase features the details of the Merck Sharp & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession, and also, lay films that can be utilized to portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products.

ELI LILLY AND COMPANY

You are cordially invited to visit the Lilly exhibit located in space No. 9. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

The following Lilly salesmen will be in attendance during the meeting.

Mr. D. M. Burns, R. Ph. (in charge of exhibit)
Mr. F. W. Medlin, R. Ph.

WM. P. POYTHRESS & CO.

A cordial welcome awaits you at the Poythress booth #33 which will feature Bensulfoid Lotion, outstanding and distinctive new treatment for acne; Synirin, for pain; and Mudrane, effective balanced formula for bronchial asthma. Solfoton, Solfoserpine, Panalgesic, and Trocinate will also be featured. Your requests for literature and professional trial supplies of any Poythress products are invited.

A. H. ROBINS COMPANY, INC.

When too much food causes your patient's complaint, prescribe AMBAR EXTENTABS (No. 1 or No. 2) to curb appetite without jitters. When too much water is his problem, prescribe the unsurpassed diuretic, NACLEX. It gets water out fast!

Also featured: DIMETANE EXTENTABS — just one provides antihistamanic relief for 10-12 hours. DONNAZYME—combines DONNATAL and ENTOZYME for "nervous indigestion."

WESTWOOD PHARMACEUTICALS

Westwood invites physicians to stop by their booth to discuss their unique dermatological products:

Fostex Cream, Fostex Cake, Lowila Cake, Lowila Emollient, Sebulex, Fostril, Alpha-Keri.

These products are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and

sensitivities to soap. Register, so that we may send prescription units to your home.

EATON LABORATORIES

Division of The Norwich Pharmacal Co.

Our Medical Service Representatives at the Eaton Booth welcome the opportunity to be of service to you. Complete information is available concerning the nitrofurans, The Eaton Medical Film Library, Student A. M. A. Photo Salon and other special services to the profession.

CHARLES C. HASKELL & COMPANY

The Charles C. Haskell Company, division of Arnar-Stone Laboratories, Inc. will introduce AZTEC for relief of asthma and bronchospasms of acute bronchitis. Also new: AMERICAINE SUPPOSITORIES.

G. D. SEARLE & CO.

Chicago, Illinois

You are cordially invited to visit the Searle Booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

WARNER-CHILCOTT LABORATORIES

Peritrate(R)—for the patient with coronary artery disease—with or without angina. Peritrate increases myocardial blood flow and oxygen supply safely—with no significant change in blood pressure, cardiac output or pulse rate.

Gelusil(R)—the physician's antacid—for lasting relief of pain and control of gastric acid by neutralization and adsorption. The unique dual gel formed by Gelusil protectively coats irritated and eroded mucosa. Gelusil is inherently nonconstipating—*contains no laxative.*

THE WARREN-TEED PRODUCTS COMPANY

The Warren-Teed Products Company will feature two specialty products at their exhibit booth No. 37.

KAON ELIXIR—An extremely palatable oral potassium.

MODANE TABLETS—A deconstipant for relief and rehabilitation of the atonic bowel.

Warren-Teed representatives cordially welcome all registrants to visit their display.

WAMPOLE LABORATORIES

AVAZYME TABLETS — The first anti-inflammatory preparation to offer high dosage enzyme therapy. AVAZYME contains 3 to 6 times more chymotrypsin than other marketed oral preparations. AVAZYME is 100% crystalline chymotrypsin.

ALVININE SHAMPOO—A new agent for the treatment of seborrhea capitis.

VoSoL/VoSoL-HC—VoSoL Otic Solution and VoSoL-HC Otic Solution, for the treatment of otitis externa without antibiotics or sulfas. VoSoL Otic Solution is bactericidal and fungicidal and may also be used for otitis prevention. The hydrocortisone in VoSoL-HC helps reduce inflammatory swelling and relieve symptoms such as itching and pain.

BREON LABORATORIES

Breon will present its complete line of antiasthmatic products: Bronkometer, Bronkospray, Bronkephrine, Bronkotabs and Bronkotab Elixir for the prophylactic and therapeutic management of bronchial asthma; Fortizyme—a new concept in anti-inflammatory therapy; Diaparene for prevention and treatment of diaper rash; Caroid & Bile Salts Tablets, and Esta products for more reliable family planning.

GEIGY EXHIBIT

Geigy cordially invites Members and Guests of the Association to visit its exhibit.

The exhibit features important new therapeutic developments in the management of inflammation, as well as current concepts in the control of hypertension and edema; depression; obesity, and other disorders, which may be discussed with physicians and representatives in attendance.

MEDICAL TELEVISION

MAY 3 - 4

THURSDAY - FRIDAY

SPACE MEDICINE

AND MEDICAL DISASTER

W. B. SAUNDERS COMPANY features the following recent books in their full page advertisement appearing elsewhere in this issue:

ADLER—TEXTBOOK OF OPHTHALMOLOGY
Concentrates on the ophthalmic problems of the non-specialist—stressing diagnosis, treatment and indications that call for a specialist.

MAJOR AND DELP—PHYSICAL DIAGNOSIS
Offers step-by-step procedures for examining every area of the body by inspection, palpation, percussion and auscultation.

REID—TEXTBOOK OF OBSTETRICS
Gives you not only a clear picture of normal pregnancy and labor, but sound insight as well into the medical complications that may arise.

Deaths

DR. E. H. MOORE

Dr. Ernest Harrison Moore, 81, died February 9 at the Newberry County Memorial Hospital.

Born in Spartanburg County, Dr. Moore graduated from the Medical College of South Carolina in 1907.

Dr. Moore had been active in his practice in Newberry County over 55 years until his most recent illness. He was one of the old-time family physicians and rendered his services throughout Newberry County and in other adjoining counties.

Dr. Moore was chief of staff of the Newberry County Memorial Hospital, and an honorary member of the Newberry County Medical Association of which he was a past president. He was also a member of the South Carolina Medical Association.

DR. S. M. BROWNE

Dr. Samuel McPherson Browne, 70, Clemson, died at an Anderson hospital March 13 following a sudden illness.

He was graduated from Anderson High School and attended Clemson College until 1911 at which time he entered the Medical College of South Carolina. He was graduated in 1914.

He entered the Army Medical School and was graduated in 1917. He remained in the Army Medical Corps until his retirement in 1947 with the rank of colonel.

He opened private practice in Clemson in 1949 and had been actively engaged in his practice until his death.

DR. LEONARD RAVENEL

Dr. Leonard J. Ravenel, 67, of Kingstree, died March 13 at Kelley Memorial Hospital after a week's illness.

Dr. Ravenel was born August 17, 1895 in Atlanta, Ga. and was graduated from the Medical College of South Carolina on June 1, 1916, with high honors.

He practiced his profession for a number of years in Florence before coming to Kingstree, where he has been engaged in private practice and scientific research for the past 19 years. He was considered an authority on internal medicine and as a diagnostician.

DR. P. M. TEMPLES

Dr. Powell M. Temples of Folly Beach, died February 11 at his residence.

Dr. Temples was born in Statesboro, Ga., August 18, 1902.

He was retired as an employee of the State Health Department and as a doctor in the U. S. Navy Medical Corps in which he had served as a lieutenant. He was a member of the South Carolina Medical Association and the International College of Chest Physicians and Surgeons.

He was educated at the University of Georgia and the University of Georgia Medical School.

DR. M. E. DIBBLE

Dr. Marvin E. Dibble, Marion County's oldest practicing physician, died February 18 at Marion County Memorial Hospital after an illness of several years. He was 83 years old, but had refused to retire from "the only thing I know."

Eight years ago, when he was 77, Dr. Dibble estimated that he had brought about 1,500 children into the world. At that time, he was taking Tuesday afternoons off and had finally stopped taking night calls.

He was born in Charleston, attended the College of Charleston and the Medical College of South Carolina there. He finished both with highest honors.

He began practicing medicine in Marion in 1903.

He served as a captain in the Army Medical Corps in World War I and as civil defense director of Marion in World War II.



Dr. Dibble was a member of the State Board of Medical Examiners for more than 35 years and president of the board for 31 years.

Active in civic affairs, he served one term in the Marion City Council and in 1955 was named Marion's "Outstanding Citizen of the Year" by the Junior Chamber of Commerce.

Public Relations

NOW HEAR THIS!!

CALLING ALL SOUTH CAROLINA DOCTORS...

In the Fight Against the King-Anderson Bill!

EDITOR'S NOTE: In March we explained that this page gives you an outline of the program and the materials available to you to help in the crucial fight against the King-Anderson Bill. Believing that the most effective campaign is implemented at the "grass roots" level, Tobias & Company of Charleston, under the supervision of your Association's Public Relations Committee, has prepared materials for you to use in your own community. The box below may be used to order these materials, including the first in a series of new radio tapes and a new booklet updating the explanation of hospital care costs.



EDITORIAL SUPPORT . .

Newest step in your public relations program.

In February, the following letter was sent to all editors of South Carolina newspapers (weeklies and dailies). The letter was accompanied by brief, factual explanations of the King-Anderson Bill versus the Kerr-Mills Law. In South Carolina medicine has always enjoyed a favorable editorial climate, and it is believed that this reminder will bring forth additional editorial support for the Association during this crucial period. Here is the letter:

"Dear Editor:

"The King-Anderson Bill is probably no stranger to you. This legislation comes before Congress this spring. If it is passed, the bill will make health care compulsory under Social Security.

"Strong political pressure groups are diligently working for the passage of this bill. It will require the concentrated efforts of all who oppose it to defeat its passage.

"Many thoughtful citizens feel that this bill is bad medicine for the country. The solution it offers is neither sound nor correct. It would most certainly cost the already burdened taxpayers a great deal of money, and it is extremely doubtful that this money would go where it is really needed.

"We are enclosing pamphlets explaining the proposed King-Anderson Bill, as well as the Kerr-Mills Law, now in effect in 38 states — including South Carolina.

"It is our belief that the Kerr-Mills Law provides a sensible answer to the problem of health care for the aged.

"If you believe as we do that the King-Anderson Bill is contrary to the best interest of our country, we would appreciate your support in helping to defeat this needless and costly extension of federal controls over medical care. Ask your own family doctor about it.

"Sincerely yours,

The S. C. Medical Assn.
Joseph I. Waring, M. D.
Chairman, Public Relations
Committee"



NEW RADIO TAPES

The program to utilize public service time on South Carolina radio stations is continuing. A new series of radio tapes, including taped statements from the state's medical and legislative leaders is now being prepared. The first of these, a statement by Dr. James H. Gressette, Orangeburg, president-elect of the State Association, is available and is listed on the order blank below.

NEW "COST OF MEDICAL CARE" BOOKLET

A revised edition of an American Medical Association booklet entitled "The Cost of Medical Care (1940-1969)" is available for distribution through physicians' offices. An important factor brought out in this 16-page cartoon-style booklet is that physicians' fees have not risen as much as the prices of many other goods and services we buy. This booklet is listed on the order blank below. If you would like additional copies for office distribution write:

Special Services Department
American Medical Association
535 North Dearborn Street
Chicago 10, Illinois



TOWN MEETING

Throughout the nation there is a revival of town hall meetings for open discussions of national and local matters of importance to the community. It is suggested that the organization of such a meeting by members of the local county medical societies could go a long way toward clearing up any points of confusion on the Kerr-Mills Law and the pending King-Anderson Bill.



SALUTE TO: The Greenville County Medical Society

We have heard good things about the Greenville County Society's public information program. They report that their speakers' bureau is active, and that the congressional writing program is making progress. Recently the Society voted money for local advertising. It has also sanctioned a medical program, sponsored by the Liberty Life Insurance Company, which is heard twice daily, five days a week. The program uses the corporate name of the Society, thus bringing it to the attention of the public frequently. An active Auxiliary has been responsible for the playing of Ronald Reagan's radio program four times over a local radio station. This active and enthusiastic program is an example of what may be accomplished on the local level. Your editor will welcome accounts from other areas, and such outstanding programs will be outlined as guides to other societies.



WHAT PRICE COMPLACENCY?

As a contrast to the active program above, there are areas of the state where some believe that it is wiser to let controversial matters remain dormant. Yet the inherent danger is still there. Like an iceberg, its real threat lies below the surface. The King-Anderson Bill is an actual and immediate threat. Can we afford complacency? What may seem to be a dormant controversy today could become the instrument to achieve socialized medicine in the nation tomorrow.

KEY TO RECORDINGS AND SPEECHES

Radio:

#1. Dr. Charles N. Wyatt, King-Anderson Bill.
#2. Quotations—Congressman Bryan Dorn and prominent S. C. Newspaper, King-Anderson Bill.
#3. King-Anderson Bill, informal down-to-earth discussion.
#4. An expose of Quackery.
#5. Dr. James H. Gressette on King-Anderson.

Speeches:

#1. King-Anderson Bill versus Kerr-Mills Law.
#2. Food Faddism.
#3. The Rising Cost of Hospitalization.
#4. Hidden Hazards (Household poisons).
#5. The Care and Preservation of the American Businessman.
#6. Mental Health.
#7. Medicine as a Career.
#8. Seven Ways to Cut Your Medical Expenses.

KERR-MILLS LAW IN SOUTH CAROLINA:

Is Kerr-Mills being implemented successfully in South Carolina?

Yes! These are the basic facts according to Mr. Arthur B. Rivers, Director, State Welfare Department, Columbia:

The Kerr-Mills Law became effective July 1, 1961. It is being implemented at the rate of five to six hundred persons each month. It is expected that this program will reach its maximum potential by January, 1963.

Who is eligible?

Single persons whose income and resources do not exceed $1,000.00 per annum plus savings of not more than $500.00 and an insurance policy with a face value of $1,000.00.

Couples whose income and resources may not exceed $1,800.00, savings of $800.00 and insurance with face value of not more than $2,000.00.

What does Kerr-Mills care provide?

Hospital care may be granted for all eligible persons diagnosed by a medical doctor as having an acute condition and requiring inpatient care, not to exceed forty days per year and three months of convalescent or nursing home care as requested by the physician with a statement to the effect that the person needs care over and above what she can receive at home. In addition, the Agency under this program does provide for certain out-patient hospital or clinic medical care service.

Is Kerr-Mills sufficient to meet medical needs in South Carolina?

Those who are most closely associated with this program are enthusiastic about its effectiveness and feel that it is an efficient and sensible method of meeting health care problems in South Carolina. Certain technical changes are being made and a revised plan, showing these changes, will be available shortly. A complete copy of the program may be secured from Mr. Arthur B. Rivers, State Director, Department of Welfare, Columbia, S. C.

ORDER BLANK

S. C. Medical Association
Public Relations Committee
P. O. Box 275, Charleston, S. C.

Please send the following:

RADIO RECORDINGS (see key below)
☐ #1 ☐ #3 ☐ #5
☐ #2 ☐ #4
☐ SPEAKERS BUREAU KITS (Quantity) _____
☐ BASIC NEWS RELEASE (Quantity) _____
SPEECHES (see key below)
☐ #1 ☐ #3 ☐ #5 ☐ #7
☐ #2 ☐ #4 ☐ #6 ☐ #8
PAMPHLETS (Quantity)
☐ "The Cost of Medical Care (1940-1960)"
☐ "Medical Aid for Aged"
☐ "Helping Those Who Need Help"
☐ "Socialized Medicine and You"
(A reprint, **Look Magazine**)

Name_____

Address_____

_____

News

Over 21,000 Get Polio Serum at Newberry

Newberry County has learned a hard lesson in what polio can do, and has made great efforts to combat the crippling disease.

On February 8 they carried out the second phase of their counterattack on polio and in March the third phase. Their concerted drive was begun last October after 22 of their number had been struck down.

The action taken after last fall's outbreak marked the first time oral polio vaccine had ever been tested under outbreak conditions in a rural area.

Under the direction of Dr. Von A. Long and Dr. C. A. Dufford, more than 21,000 persons—"from three months to the grave"—came to immunization centers where they were given doses of Sabin oral vaccine.

In October they received Type III vaccine, in February Type I and in March they received Type II.

Newberry County is the first county in the nation whose rural population received the full immunity provided by all three types of oral polio vaccine.

Pediatricians Move to New Center

Dr. Griggs C. Dickson and Dr. James C. Parke, pediatricians, have moved to their new Children's Medical Center located at 800 Carolina Avenue, Hartsville.

Dr. Fennell Returns

Dr. Wallace W. Fennell has returned to Rock Hill after spending more than two years in the South Pacific. Dr. Fennell and Dr. S. H. Shippey, also of Rock Hill, were in charge of the Kwajalein Naval Base hospital in the Marshall Islands.

Chest Physicians Establish Resident Loan Fund

The American College of Chest Physicians has established a fund providing for loans to resident physicians to stimulate interest in postgraduate study of chest diseases and to assist postgraduate students in continuation of studies in diseases of the chest (including diseases of the heart and lungs).

Any physician who has completed an internship of one year or more in an acceptable hospital may apply for a loan to continue in the specialty of chest diseases. Loans are made only to physicians serving residencies in chest medicine and cannot be made to physicians engaged in practice.

Application forms may be secured by writing to the Committee on Resident Loan Fund, in care of the Executive Offices of the American College of Chest Physicians, 112 E. Chestnut Street, Chicago 11, Illinois.

Symposium on Clinical Allergy

Mound Park Hospital Foundation, Department of Medical Education of Mound Park Hospital, Research Division Bay Pines V. A. Center, A.A.G.P.—April 19 to 21 inclusive. Limited to 35 physicians. Fee $40.00. 12 Credit Hours Category 1 allowed. Address ALLERGY, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida.

Dr. Ennis Opens Office

Henry R. Ennis, M. D., F. A. C. S. announces the opening of his office for the practice of orthopedic surgery in Burndale Shopping Center, Camden.

Dr. Pearce Honored By Legislature

Dr. J. C. Pearce, of Graniteville was commended for his half-century of service to Graniteville in devoted practice of medicine by a concurrent resolution introduced in the General Assembly of South Carolina by Representatives May, Baker and Simons.

The resolution follows:

A CONCURRENT RESOLUTION
COMMENDING
DR. J. C. PEARCE,
OF GRANITEVILLE, SOUTH CAROLINA,
FOR HIS FAITHFUL AND DEVOTED PRACTICE OF MEDICINE FOR MORE THAN FIFTY YEARS.

WHEREAS, Dr. J. C. Pearce, of Graniteville, South Carolina, has been practicing medicine for more than fifty years in that community; and

WHEREAS, his practice has carried him from the "horse and buggy days" with a limited supply of medicine in his black satchel to the days of modern transportation and wonder drugs, with which he has so carefully treated his beloved patients; and

WHEREAS, with his helpmate, the former Margaret Eldridge Henderson, he has brought cheer and hope to many families of this community; and

WHEREAS, he is looked to with love and gratitude by three generations of the community's residents.

NOW, THEREFORE ,

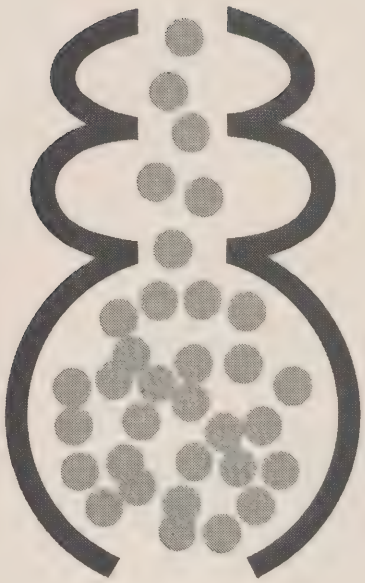
BE IT RESOLVED by the House of Representatives, the Senate concurring:

THAT the General Assembly commends Dr. J. C. Pearce for his long, cheerful, diligent and dedicated service to the people of Graniteville.

Dr. Sol Neidich Is Re-Elected To Hospital Post

Dr. Sol Neidich of Beaufort was re-elected a trustee of the National Jewish Hospital, free, nonsectarian chest disease center at Denver.

The hospital pioneered the treatment of tuberculosis



LOMOTIL®

(brand of diphenoxylate hydrochloride with atropine sulfate)

ANTIDIARRHEAL TABLETS and LIQUID

lowers motility / relieves cramping / controls diarrhea

Roentgenographic studies by Demeulenaere[1] established that a single dose of 10 mg. of Lomotil slowed gastrointestinal transit within two hours and that it maintained its decelerating activity for more than six hours.

In diarrhea this lowered propulsion permits a physiologic absorption of excess fluid, lessens frequency and fluidity of stools and gives safe, selective, symptomatic control of most diarrheas. Concurrently, it conserves electrolytes and controls cramping.

Investigators have found the antidiarrheal action of Lomotil not only "excellent"[2] but "efficacious[3] where other drugs have failed. . . ."

DOSAGE: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

NOTE: Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.: Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine

with drugs. It also treats and does laboratory research into all chest diseases including cystic fibrosis, and heart defects correctible by surgery.

Opened by the B'nai B'rith and the Denver Jewish community in 1899, it has provided a total of more than 4¼ million patient-days of free care to patients of all races and creeds. Patients from South Carolina alone have received 11,636 days of care under the motto: None may enter who can pay — None can pay who enter.

Winning Fight Against Rabies Draws Praise

An open letter to all veterinarians, county and municipal health officers, sanitarians and county public health personnel has been issued commending them on their "interest, work and hearty cooperation" in making 1961 a clear year for rabies.

The letter, sent out by Dr. Frank M. Lee, public health veterinary consultant with the State Board of Health, said 1961's record of no rabies "is the culmination of 11 years of a program which so far has been very successful." He said that because of their work with many groups of people as well as many individuals the program was made possible.

Dr. Leon Banov Receives Sertoma Award

Dr. Leon Banov, Charleston County Public Health Director for 25 years, has been named to receive the Coastal South Carolina District of Sertoma International "Service to Mankind Award."

The award, presented at a formal testimonial dinner February 21 makes him eligible for consideration for Sertoma's International Award.

"The award is made annually to the individual who has in the opinion of the judges, faithfully and unselfishly served his fellow man," Edward B. Medows, governor of the Coastal Carolina District said.

"Dr. Banov was selected for this recognition not only because he has devoted a lifetime to the well-being of his fellow citizens, but also because we feel that his career of service exemplifies the American way of life." Mr. Medows said.

Record of Achievement

The year that recently closed was a year of steady progress in medical research and in clinical medicine. That is the gist of a poll of deans of medical schools which was made by the American Medical Association.

Here are a few highlights which the deans noted: Rapidly expanding knowledge in medical genetics, so important that the time is now approaching when many very serious human diseases may be eliminated entirely; new forward strides in the search for drugs that will cure or prevent cancer; development and discovery of new pharmaceuticals, particularly the new live polio vaccine, the measles vaccine, and synthetic penicillin; important new knowledge about hepatitis which may eventually lead to a vaccine against the one remaining epidemic disease which is still increasing in the United States; progress in the application of electronics and computers to medicine, a further bringing together of machinery and equipment, skills and techniques, men, money and methods to the benefit of mankind.

So the story goes—a story which brings new hope and health to legions of people. It is a story of medical achievement, in all its many and varied branches, under a free system. Who can say, with reason or justice, that this country needs, wants, or can afford socialized or government medicine?

The Union Daily Times January 24, 1962

False Labels

The Food and Drug Administration has announced seizure of two antibiotic preparations charging that promotional literature sent to physicians differs widely from the labeling which was the basis of the original safety clearance.

FDA said a quantity of Tain Oral Suspension and Tain Antibiotic Decongestant Analgesic tablets, shipped by Dorsey Laboratories, Lincoln, Neb., were seized at three dealers in Kansas City, Mo. The drugs combine the antibiotic triacetyloleandomycin with decongestant, antihistimine, analgesic and antipyretic compounds.

FDA charged that promotional literature to physicians contains claims not found in the labeling with the New Drug Applications. The agency said the preparations are therefore new drugs for which the applications are not effective, that the labeling makes false claims and that it fails to bear adequate directions for use.

New Drug Applications for the products were cleared with labeling specifically for symptomatic relief of the common cold and the prevention of secondary infections, FDA said. The accepted labeling included the caution that if resistant infection or superinfection appears these drugs should be discontinued and appropriate treatment started.

FDA said statements in a promotional folder, "Time to Take 'Em Out Again," mailed to physicians, made the following claims for the products:

That the drugs are adequate and effective as treatment for tonsilitis, pharyngitis, otitis media, bronchitis, pneumonitis, bronchopneumonis, rhinitis, cervical lymphadenitis, coryza, lobar pneumonia, tracheitis, influenza, adenoiditis, bronchial asthma, croup and post-nasal infection.

The product was also considered misbranded in that it made false claims which included: That analgesic ingredient, acetaminophen, is safer in children than salicylates and its antipyretic effect does not mask the diagnostic importance of persistent fever.

FDA charged that Tain Oral Suspension was further misbranded because statements in the folder falsely claimed any side effects seen are not usually caused by the product and that children do not become drowsy from antihistamines.

AMEF

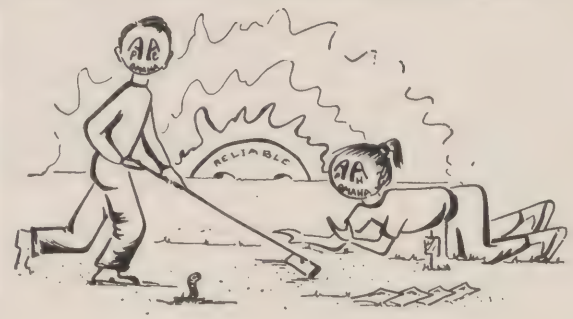
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American Medical Education Foundation

535 N. Dearborn St., Chicago 10, Ill.

If you are a male psychiatrist under the age of 50, have your Boards or are Board eligible, you may be interested in directing a private established out-patient psychiatric clinic in a favorable setting that offers rewarding work and $25,000 per year, net.

Write Box 1 care of this Journal.



Protection against loss of income from accident & sickness as well as hospital expense benefits for you and all your eligible dependents.

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Handsome Professional Appointment Book sent to you FREE upon request.



WELCH ALLYN

lights the way to fast, accurate diagnosis with easy-to-use, dependable instruments.

Set shown includes Welch Allyn's 110 ophthalmoscope, 216 otoscope with 5 polypropylene specula, and 700 large battery handle, in deluxe 21-L case. $80.50.

Many other Welch Allyn combination sets are available, with different otoscopes and ophthalmoscopes, in regular, deluxe or compact cases, with standard or rechargeable battery handles, from $73.00 to $94.00.

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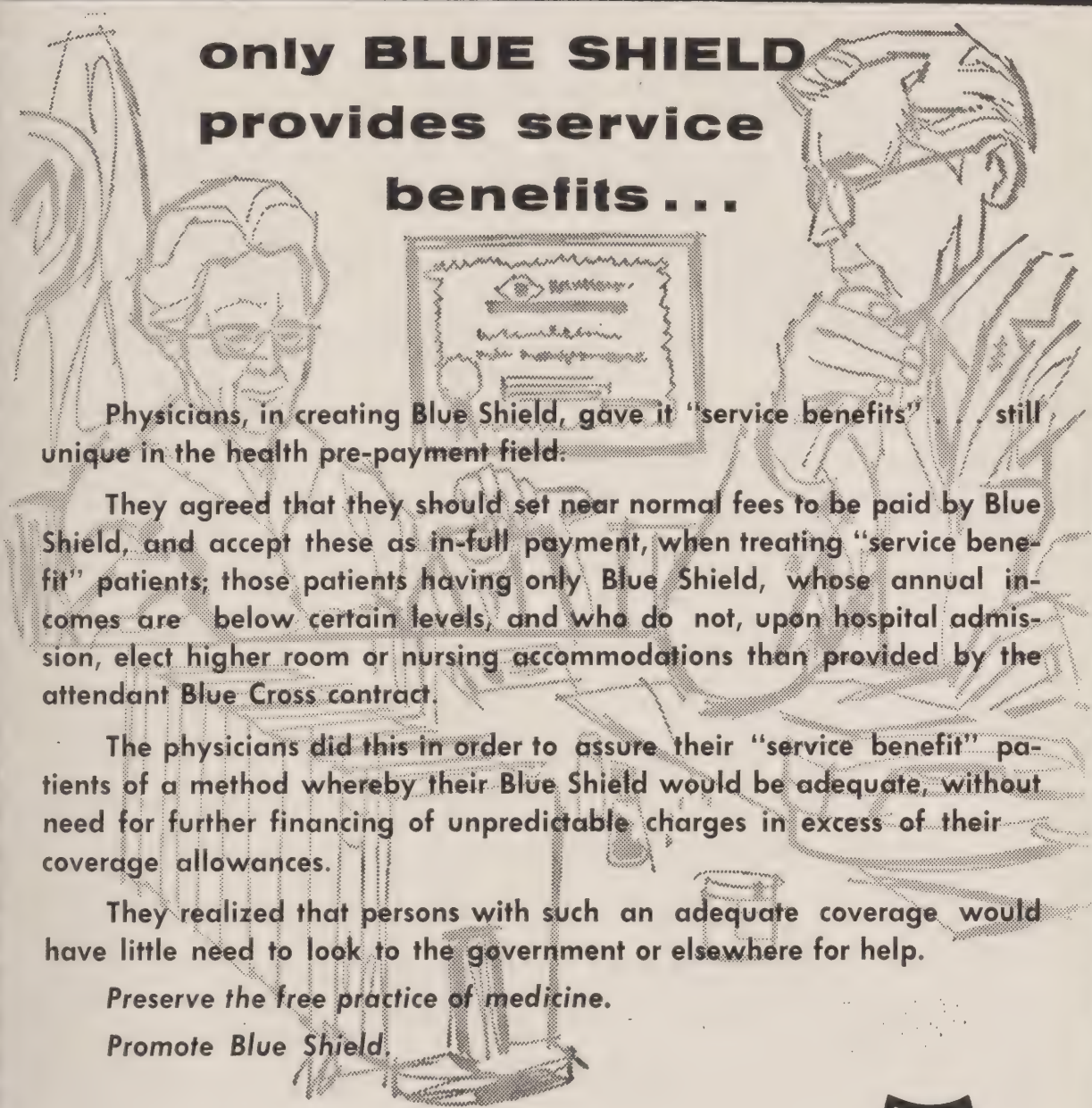
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They agreed that they should set near normal fees to be paid by Blue Shield, and accept these as in-full payment, when treating "service benefit" patients; those patients having only Blue Shield, whose annual incomes are below certain levels, and who do not, upon hospital admission, elect higher room or nursing accommodations than provided by the attendant Blue Cross contract.

The physicians did this in order to assure their "service benefit" patients of a method whereby their Blue Shield would be adequate, without need for further financing of unpredictable charges in excess of their coverage allowances.

They realized that persons with such an adequate coverage would have little need to look to the government or elsewhere for help.

Preserve the free practice of medicine.

Promote Blue Shield.

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THE AMERICAN CANCER SOCIETY

is dedicated to saving lives from cancer and spearheads the fight against cancer quackery. Its Committee on New or Unproved Methods of Treatment of Cancer has a membership of physicians, lawyers, educators, and public relations specialists. This committee has been a prime mover in developing constructive action

against cancer quackery

Inspired by model legislation formulated by this committee with the active cooperation of the California Medical Association, California, Kentucky and Nevada recently passed bills providing the first effective means of fighting cancer quackery at its base of operations—in the local community.

To keep both the public and the medical profession informed, the Society has established, in its national office, a central repository of material on new or unproved methods of cancer diagnosis, treatment and cure—a principal source of such information in this country.

The American Cancer Society, in this as in all its efforts, serves both the private citizen and the practicing physician—and is, in turn, served by both.



THE AMERICAN CANCER SOCIETY



There's nothing
like a vacation* for
easing stress-induced
smooth muscle spasm

...nothing, that is,
except autonomic sedation with

DONNATAL®

Natural belladonna alkaloids plus phenobarbital

*This one at Mirror Lake, Yosemite Park

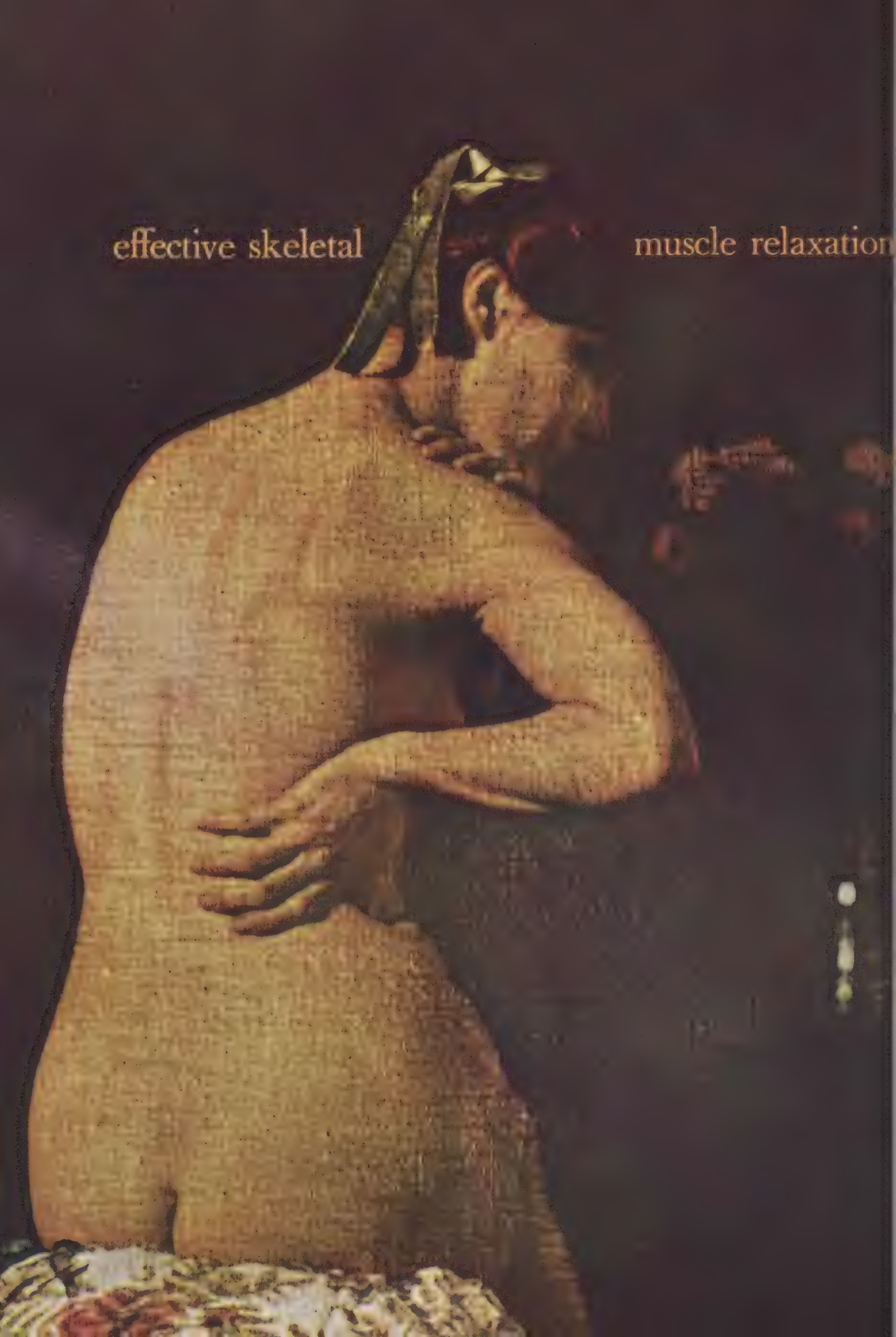
Prescribed by more physicians
than any other antispasmodic

In each DONNATAL Tablet, Capsule or 5 cc. Elixir		In each DONNATAL Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital	(¾ gr.) 48.6 mg.

A.H. ROBINS CO., INC. • Richmond, Virginia

DONNATAL tablets • capsules • elixir
— for an easily adjusted t.i.d. or q.i.d. dosage regimen.

DONNATAL EXTENTABS®
— for day-long or night-long benefits on a single dose.


effective skeletal
muscle relaxation

as each patient may require

—for dramatic promptness: ROBAXIN INJECTABLE usually provides relaxation of painful spasm *in minutes*. Clinicians have reported that it is "effective in producing immediate relaxation,"[7] and brings about "dramatic relief of pain and spasm" within 15 to 20 minutes.[3]

In each 10-cc ampul Methocarbamol (Robins) 1.0 Gm.

—for prolonged use with safety: ROBAXIN TABLETS safely maintain relief of spasm *without drowsiness*. "The effect does not wax and wane,"[4] and continued administration shows "no deleterious effect on normal muscle tone."[6]

In each white, scored tablet Methocarbamol (Robins) 0.5 Gm.

ROBAXIN®

Robaxin is methocarbamol (Robins) U. S. Pat. No. 2770649

—for concurrent analgesia: ROBAXISAL TABLETS, combining ROBAXIN with aspirin, are useful in spasm-triggering states that are painful in themselves, or when pain is prominently associated with muscle spasm.

In each pink-and-white laminated tablet Methocarbamol (Robins) 400 mg.
Acetylsalicylic acid (5 gr.) 325 mg.

—for concurrent analgesia plus sedation: ROBAXISAL-PH TABLETS, combining ROBAXIN with the sedative-reinforced analgesic PHENAPHEN®, are particularly helpful in giving comprehensive relief to patients in whom muscle spasm is accompanied by spasm-potentiating pain and apprehension.

In each green-and-white laminated tablet			
Methocarbamol (Robins)	400 mg.	Acetylsalicylic acid (1¼ gr.)	81 mg.
Phenacetin	97 mg.	Hyoscyamine sulfate	0.016 mg.
		Phenobarbital (⅛ gr.)	8.1 mg.

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References: 1. Carpenter, E. B.: South. M. J. 51:627, 1958. 2. Hudgins, A. P.: Clin. Med. 8:243, 1961. 3. Lamphier, T. A.: J. Abdomin. Surg. 3:55, 1961. 4. Levine, I. M.: Med. Clin. N. America 45:1017, 1961. 5. Meyers, G. B., and Urbach, J. R.: Penna. M. J. 64:876, 1961. 6. Perchuk, E., Weinreb, M., and Aksu, A.: Angiology 12:102, 1961. 7. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 8. Schaubel, H. J.: Orthopedics 1:274, 1959. 9. Steigmann, F.: Am. J. Nursing 61:49, 1961.

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control the two-headed dragon of *pain & spasm*

"HIGH THERAPEUTIC EFFECT"

A growing library of clinical reports on the use of ROBAXIN in painful skeletal muscle spasm continues to reaffirm its effectiveness, dependability, rapidity of action, and lack of significant side effects.

Some recent comments:

"...high therapeutic effect..."[5]

"...superior to other relaxants..."[9]

"...remarkably effective..."[2]

"...a high potential for prompt relief..."[8]

"...unusual freedom from toxicity..."[1]



In acne—24-hour-a-day skin care with antibacterial pHisoHex®

(contains 3% hexachlorophene)

In acne, pHisoHex, antiseptic detergent, provides *continuous* antibacterial action against the infection factor. With exclusive, frequent use, pHisoHex builds up an effective antibacterial film on the skin that resists rinsing—lasts from wash to wash. pHisoHex augments any other therapy of acne.

When pHisoHex was used for washing by 42 patients with acne, "the results were uniformly encouraging. . . ."[1] "No patient failed to improve."[1]

pHisoHex cleans the skin of acne patients better than soap because it is forty per cent more surface active. It is a powerful emulsifier of oil, an action particularly beneficial in acne. Moreover, it cleans the orifices of the sebaceous glands, sweat glands and hair follicles more rapidly and more thoroughly than soap. pHisoHex lacks the potentially harmful qualities of soap. It is nonalkaline, nonirritating and hypoallergenic.[2]

For acne, prescribe pHisoHex—and get improved results.

pHisoAc® Cream dries, peels and masks lesions. Use it with pHisoHex washings to help prevent comedones, pustules and scarring. Contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent and hexachlorophene 0.3 per cent.

pHisoHex is available in unbreakable squeeze bottles of 5 oz. and 1 pint—and in combination package with pHisoAc Cream.

1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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Another example of how SEALY



POSTUREPEDIC CAN HELP

CASE 265

My wife had trouble with her back for several years, and four years ago had a ruptured disc. Before we got our Sealy Posturepedic she complained each morning about a stiff back and couldn't move around, but now she feels just wonderful when she gets up. There is no stiffness in her back at all. Our Sealy mattress is in our home to stay.

(Excerpt of letter from Mr. H. H., Winston-Salem, N. C. Name available on request.)



Sealy

You know that chronic lower back trouble is not a simple matter. The Posturepedic mattress, then, cannot be a "cure." But patients who have tried Posturepedic and doctors who use it, too, know it *can help*. They find the firm, level support Posturepedic gives to spine and muscular system in back and limbs promotes normal, healthful sleep among *all* persons.

The Sealy Posturepedic, as you undoubtedly know, is designed in cooperation with leading orthopedic surgeons. We believe your investigation and *personal use* will firmly convince you of its distinctive benefits and, we would hope, merit your valued recommendation. Why not prove it to yourself by taking advantage of this liberal professional discount plan now?

We invite you to take advantage of a professional discount

This is a saving of $39 per set over the regular retail price for innerspring mattress and matching foundation. Limit: one full or two twin size sets. MAIL TO: Sealy Mattress Co., 666 N. Lake Shore Dr., Chicago 11

☐ Enclosed is my check. Please send the Sealy Posturepedic set(s) indicated below.

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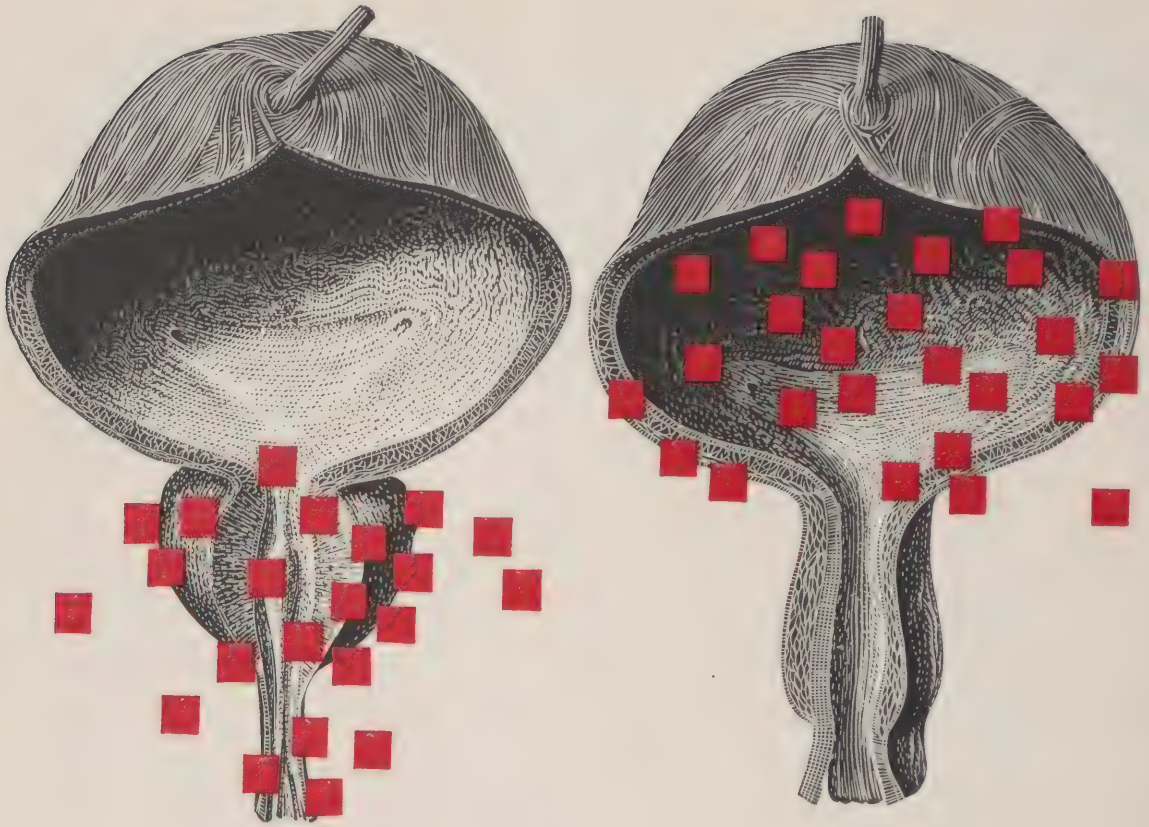
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*City*_____ *Zone*_____ *State*_____

SEALY, INC., 666 N. LAKE SHORE DRIVE, CHICAGO 11, ILLINOIS

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Serenium

Squibb Ethoxazene (Diamino-Ethoxy-Azobenzene Hydrochloride)

Quickly eliminates pain and burning in the lower urinary tract

At real savings to your patients

Serenium provides **quick, localized analgesic action** in acute and chronic urinary tract infections with **only 1 tablet** t.i.d. Your patient is assured of the prompt action of Serenium by the harmless orange-red color of the urine; and he will feel good about the **low prescription cost,** too.

Supply: Bottles of 50 and 500 chocolate-covered tablets. Each tablet contains 0.1 Gm. of Squibb Ethoxazene. For full information see your Squibb Product Reference or Product Brief.

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SQUIBB *Squibb Quality—the Priceless Ingredient*

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Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



"All the world's a stage..
And one man in his time
plays many parts,
His acts being seven ages..."*

*As You Like It, Act II, Sc. 7

through all seven ages of man

VISTARIL®

effective anxiety control
with a wide margin of safety

in the "frantic forties"—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

In each of these areas, VISTARIL is often effective alone or as an adjunct to other therapy. For example, in his series of 67 patients, King[1] found that 62 showed remission of anxiety, tension, nervousness and insomnia, as well as alleviation of symptoms associated with various functional and psychophysiological disturbances. He concludes that VISTARIL is well suited for use in the practice of internal medicine.

In the emergent situation, VISTARIL, administered parenterally, is a valuable aid to the physician in managing patients who escape psychic conflict via alcohol. According to Weiner and Bockman,[2] who obtained beneficial results in 81% of 175 patients studied, hydroxyzine (VISTARIL) may well be considered a tranquilizer of choice in the management of the acutely agitated alcoholic.

1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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See "In Brief" on the next page.

IN BRIEF VISTARIL®

VISTARIL, hydroxyzine pamoate (oral) and hydroxyzine hydrochloride (parenteral solution), is a calming agent unrelated chemically to phenothiazine, reserpine, and meprobamate.

VISTARIL acts rapidly in the symptomatic treatment of a variety of neuroses and other emotional disturbances manifested by anxiety, apprehension, or fear—whether occurring alone or complicating a physical illness. The versatility of VISTARIL in clinical indications is matched by wide patient range and a complete complement of dosage forms. The calmative effect of VISTARIL does not usually impair discrimination. No toxicity has been reported with the use of VISTARIL at the recommended dosage, and it has a remarkable record of freedom from adverse reactions.

INDICATIONS: VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

ADMINISTRATION AND DOSAGE: Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

SUPPLIED: VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

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Textbook after textbook, article after article and experience in practice after practice consistently have demonstrated the capacity of Demerol to produce satisfactory analgesia without weakening the intensity of uterine contractions. In fact, many observers have reported an apparent shortening of labor, particularly in the primipara.

Because it is well tolerated by both the mother and the newborn child, Demerol is generally considered one of the safest analgesics for use in obstetric practice.

In addition to satisfactory analgesia, a moderate sedative effect is obtained with large doses, and sleep is frequently induced between pains.

In 13,000 deliveries reported by 158 physicians, "Demerol was unquestionably the narcotic of choice during labor."

(Questionnaire, The Maternal and Child Welfare Committee, South Dakota State M. A., 1958)[1]

"Demerol is our drug of choice for analgesia during labor."

(Posner, Fielding and Posner, Harlem Hospital, New York City)[2]

Demerol in combination with scopolamine ". . . offers the best means of securing analgesia and amnesia in labor with the least risk to the mother and child. . . . Often one is amazed at the manner in which the cervix melts away under this form of medication."

(Beck and Rosenthal, State University of New York)[3]





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"When combined with scopolamine, it [Demerol] can produce satisfactory amnesia-analgesia in over 90% of the mothers during labour."

(Hershenson and Reid, Boston Lying-in Hospital and Harvard M. Sch.)[4]

In one of the most commonly used technics, an initial dose of 100 mg. of Demerol and 1/150 grain of scopolamine is given intramuscularly when labor is established. Subsequently, 100 mg. of Demerol are given every four hours and 1/200 grain of scopolamine every three hours. "Within 15 or 20 minutes the pain is relieved and neither the frequency nor the intensity of the uterine contractions are diminished."

(Beck and Rosenthal)[3]

Demerol is "... an analgesic drug which relieves pain about as well as does morphine, and it has in addition an antispasmodic action which makes it a good preparation for use during labor. . . . It may be given alone but its effect is enhanced when it is used in combination with scopolamine, and the resultant amnesic effect is excellent."

(Titus, Pittsburgh)[5]

SIDE EFFECTS AND CONTRAINDICATIONS: Demerol hydrochloride is generally well tolerated and nontoxic in therapeutic doses. Side effects occur more frequently in ambulatory patients (who should therefore be specially cautioned) than in those confined to bed. Dizziness is the most common reaction. Nausea or vomiting occurs less frequently than after administration of morphine. Flushing of the face, sweating and dryness of the mouth are sometimes noted. More severe reactions are characterized by great weakness, syncope, profuse perspiration, marked dizziness, and nausea and vomiting. They usually can be prevented if the patient lies down promptly at the onset of side effects. Tolerance to side effects usually develops quickly if medication is continued in small doses (25 mg.). In contrast to morphine, respiratory depression occurs infrequently. However, in patients with lesions that cause increased intracranial pressure, respiratory depression has been noted; therefore, the drug is considered to be contraindicated in such persons.

When Demerol with Scopolamine is used, idiosyncrasy to scopolamine may be encountered occasionally, producing the paradoxic effect of excitement, restlessness, hallucinations and delirium instead of sedation and amnesia. In addition, edema of the uvula, glottis and lips may be encountered occasionally in extremely hypersensitive patients.

Nalorphine (Nalline®) or levallorphan (Lorfan®) are considered to be specific antidotes against respiratory depression which may result from overdosage or unusual sensitivity to narcotics including Demerol.

1. Ranney, Brooks: *South Dakota J. Med. & Pharm.* 11:479, Dec., 1958.
2. Posner, L. B.; Fielding, W. L., and Posner, A. C.: *Obst. & Gynec.* 2:81, July, 1953.
3. Beck, A. C., and Rosenthal, A. H.: Obstetrical Practice, ed. 7, Baltimore, The Williams & Wilkins Company, 1958, pp. 1029, 1030.
4. Hershenson, B. B., and Reid, D. E.: *Bull. Narcotics* 8:36, July-Sept., 1956.
5. Titus, Paul: The Management of Obstetric Difficulties, ed. 5, St. Louis, C. V. Mosby Co., 1955, p. 617.

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pH of Demerol 5% and 10% solutions in ampuls and vials is adjusted between 4.5 and 6.0 with sodium hydroxide or hydrochloric acid. Multiple dose vials of Demerol solution also contain metacresol 0.1 per cent as preservative.

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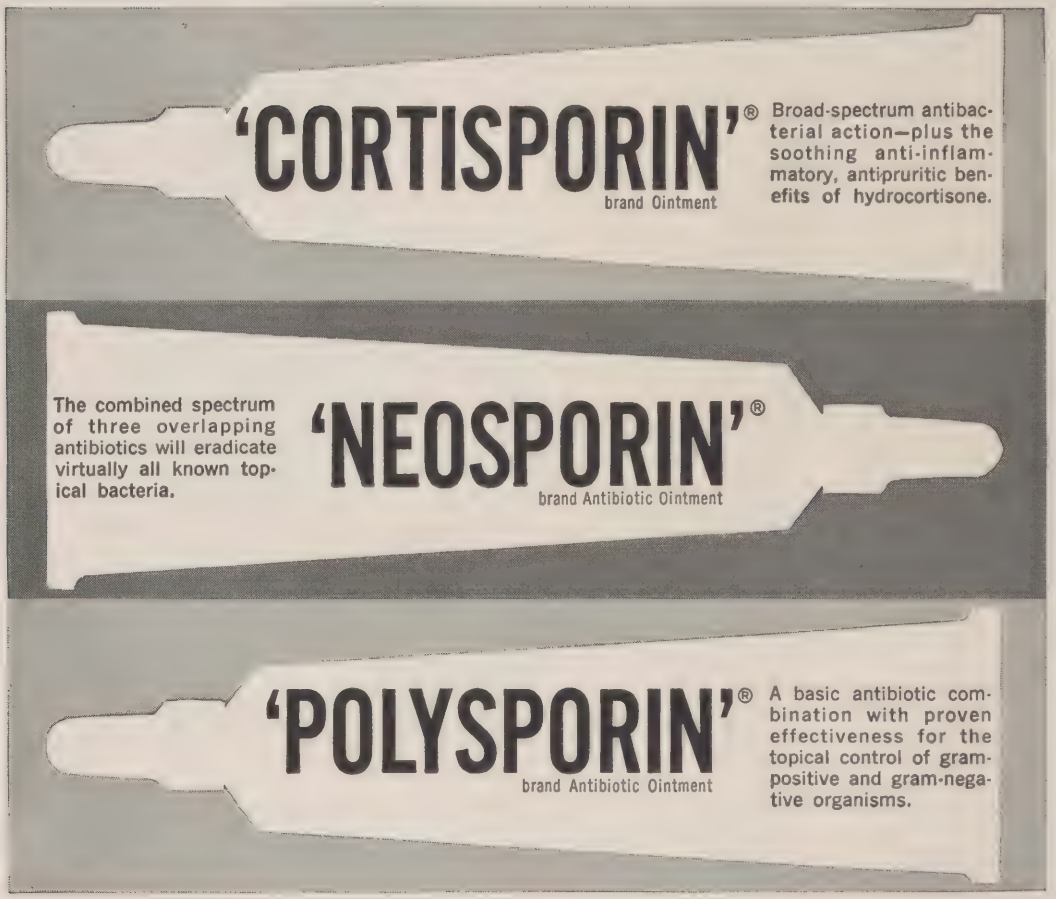
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References: 1. Berenbaum, M.C. et al.: Blood 15:540, 1960. 2. Shapleigh, J.B. and Montgomery, A.: Am. Prac. & Digest Treat. 10:461, 1959. 3. Swan, H.T. and Jowett, G.H.: Brit. M.J. 2:782 (Oct. 24) 1959.

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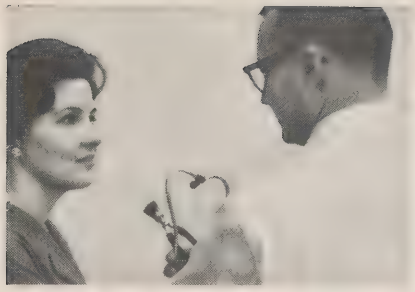
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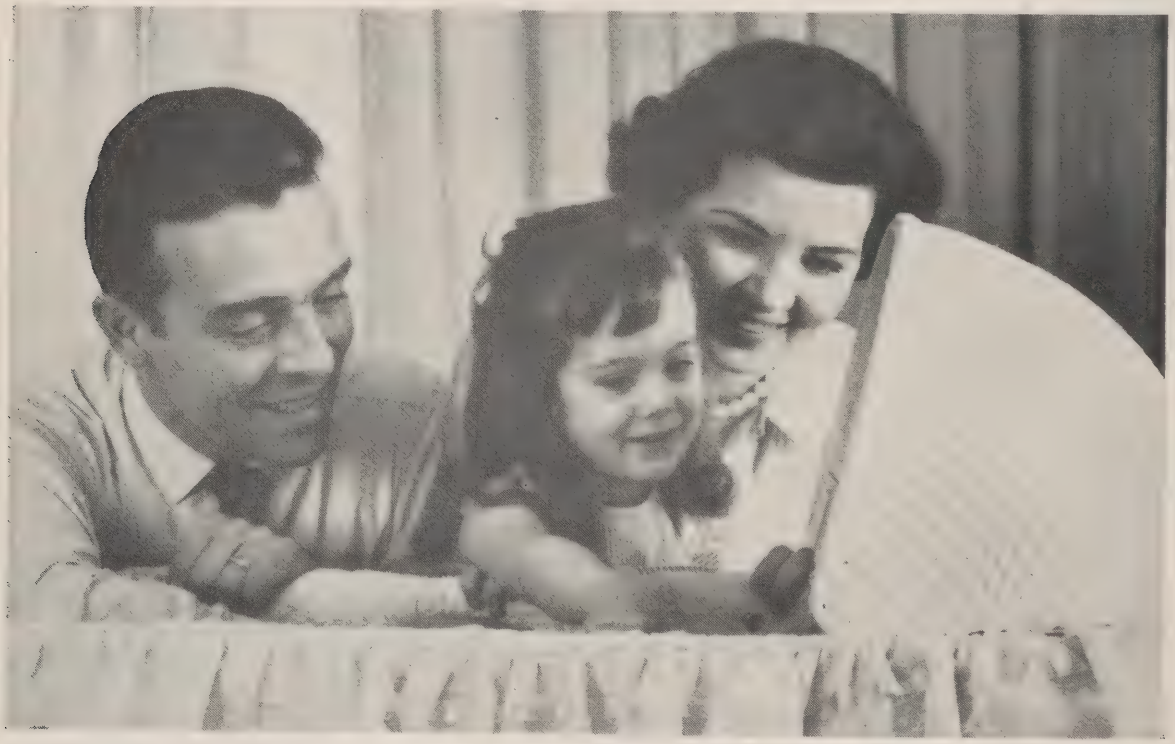
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*Gamble, C.J.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960. See also Berberian, D.A., and Slighter, R.G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Kaufman, S.A.: Obst. and Gynec. *15*:401 (March) 1960; Warner, M.P.: J.Am.M. Women's A. *14*:412 (May) 1959.

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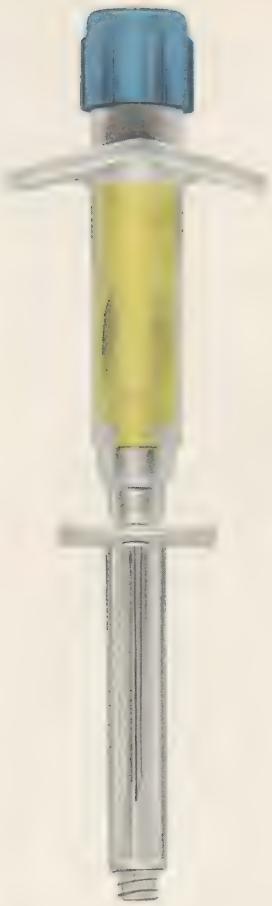
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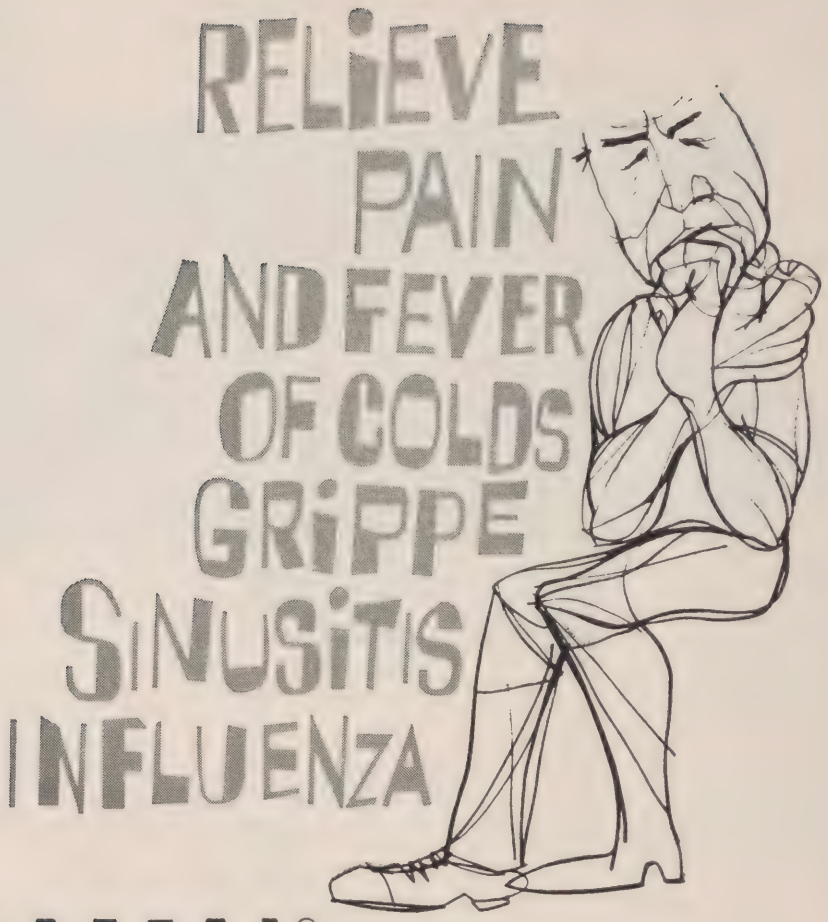
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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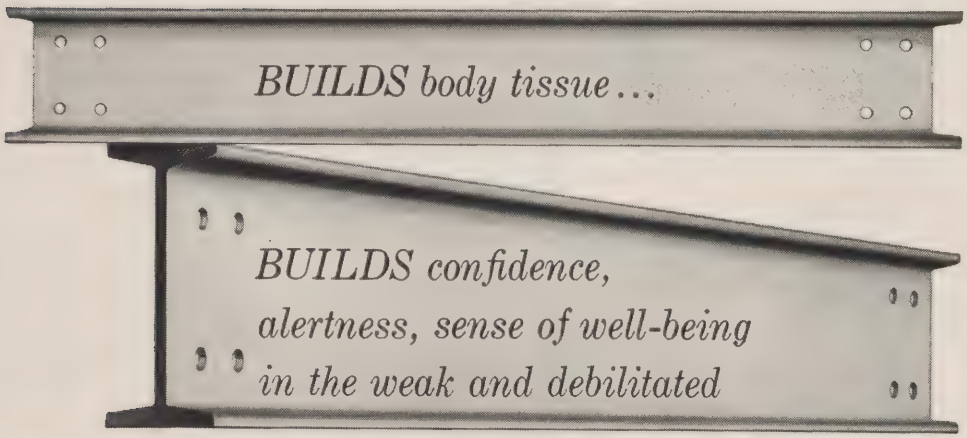
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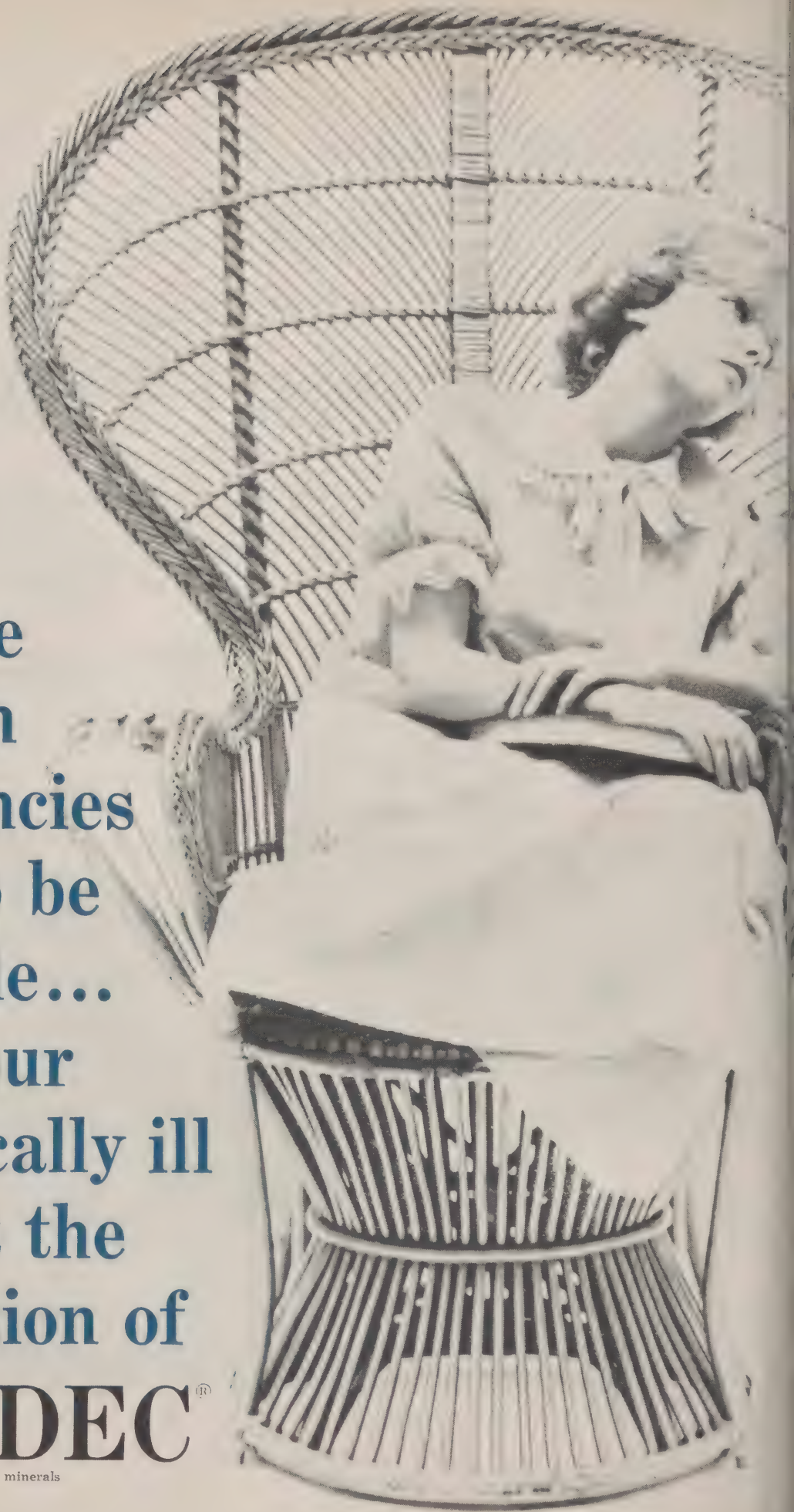
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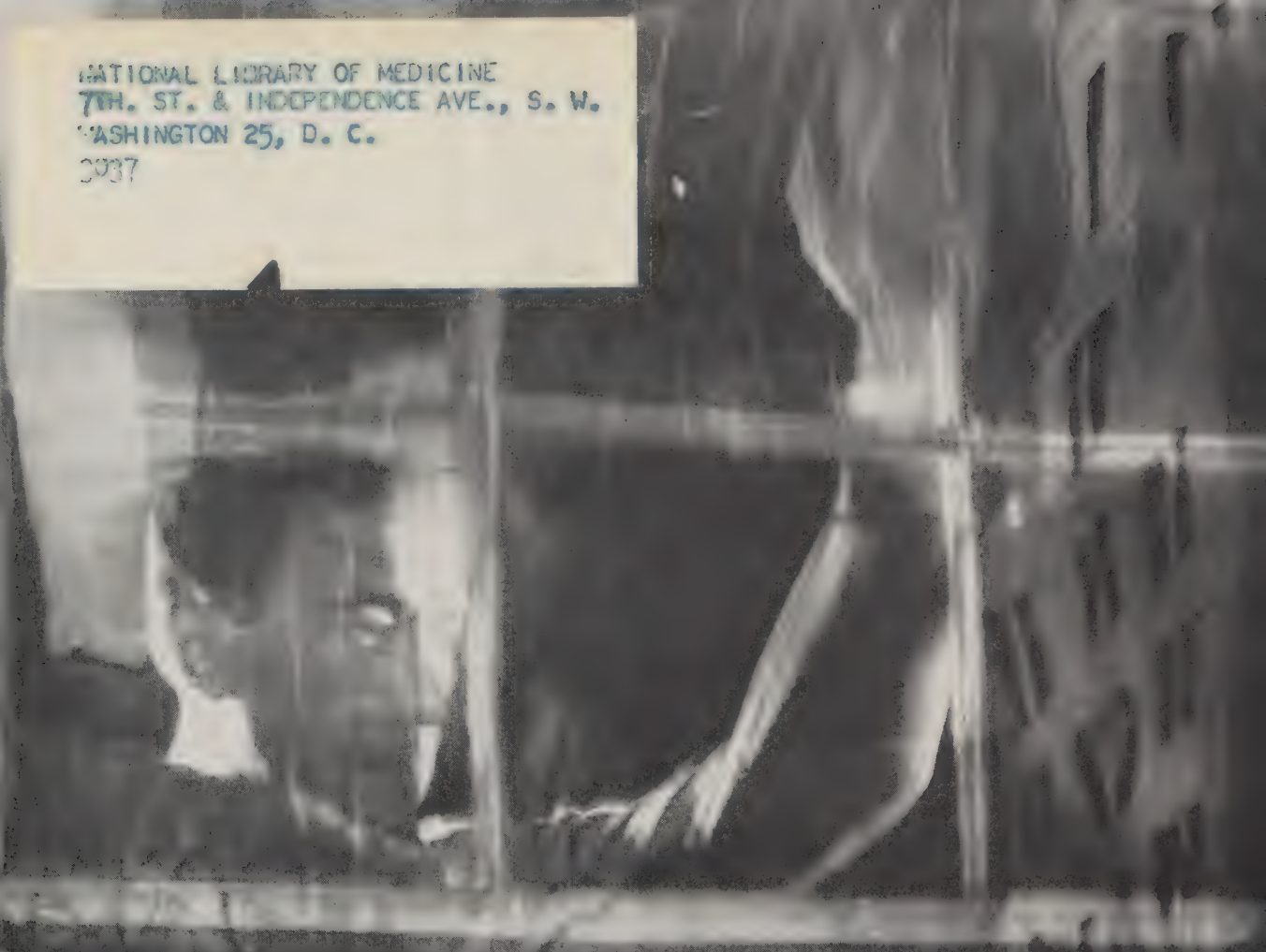
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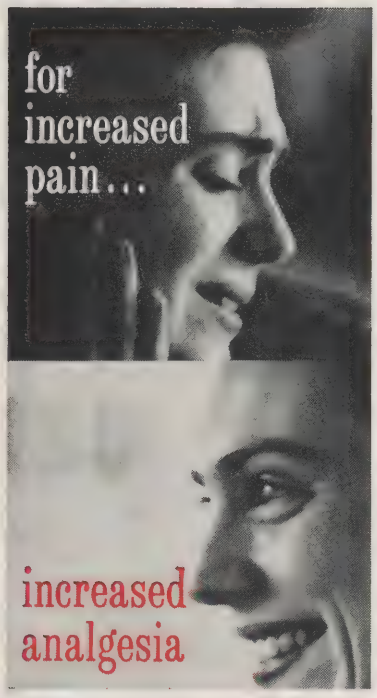
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Pakistan Medicine
Dr. Tucker Harris
Psychology of Children
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1. Dextroposition 2. Barbiturate Poisoning
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*Schwartz, I. R..
Current Therap. Res. 3:29, Feb., 1961.

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ORIGINAL ARTICLES

Caruncle or Carcinoma?—*Buford S. Chappell, M. D.* ---------- 167
Pakistan Medicine—*Jane L. Blakely* ---------- 170
Management of Human Leukemias and Hodgkin's Disease with Dopan (Uracil Mustard)—*John R. Sampey* ---------- 175
Dr. Tucker Harris and Colonial Physicians—*F. Eugene Zemp, M. D.* ---------- 177
The Psychologic Care of Children—*R. M. Pollitzer, M. D.* ---- 180

MEDICAL COLLEGE CLINICS

Electrocardiogram of the Month—Dextroposition—*Dale Groom, M. D.* ---------- 183
Poisoning of the Month—*Margaret Q. Jenkins, M. D.* ---------- 184
Dermatological Don'ts—Tinea Versicolor—*Kathleen Riley, M. D.*--- 185

EDITORIALS

Health Agencies ---------- 187
Canadian Compulsion ---------- 187
This Wormy World! ---------- 187

FEATURES

President's Page ---------- 156
News ---------- 189, 198
Public Relations ---------- 193
Civil Defense ---------- 196
Status in Medicine—Bernard E. Ferrara ---------- 197
Book Reviews ---------- 201

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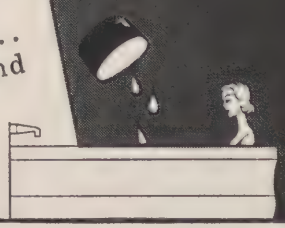
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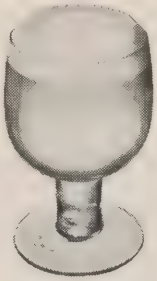
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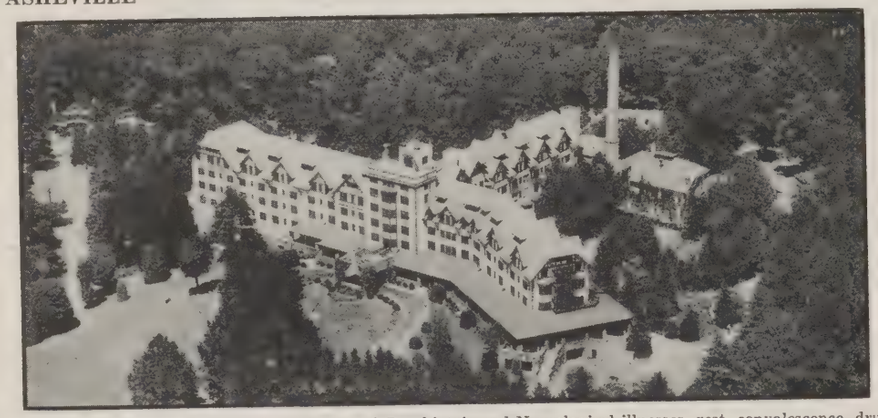
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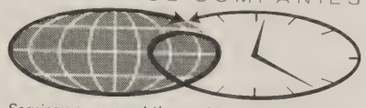
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Rubin, W. and Anderson, J. R.: Angiology 9:256, 1958.

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Wilmot, T. J. and Seymour, J. C.: Lancet 1:1098, 1960.

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Seymour, J. C.: Laryngology & Otology 74:133, 1960.

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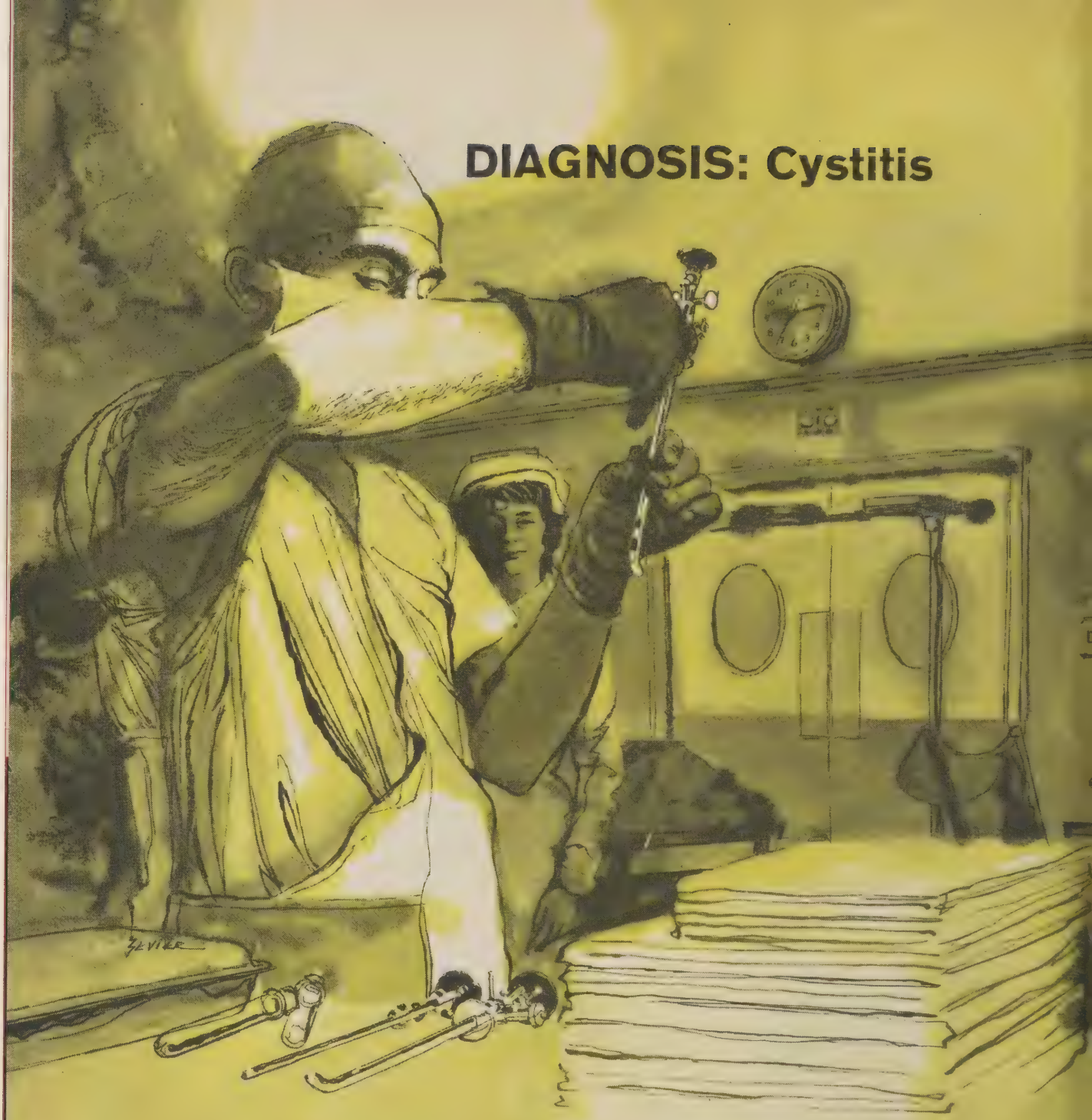
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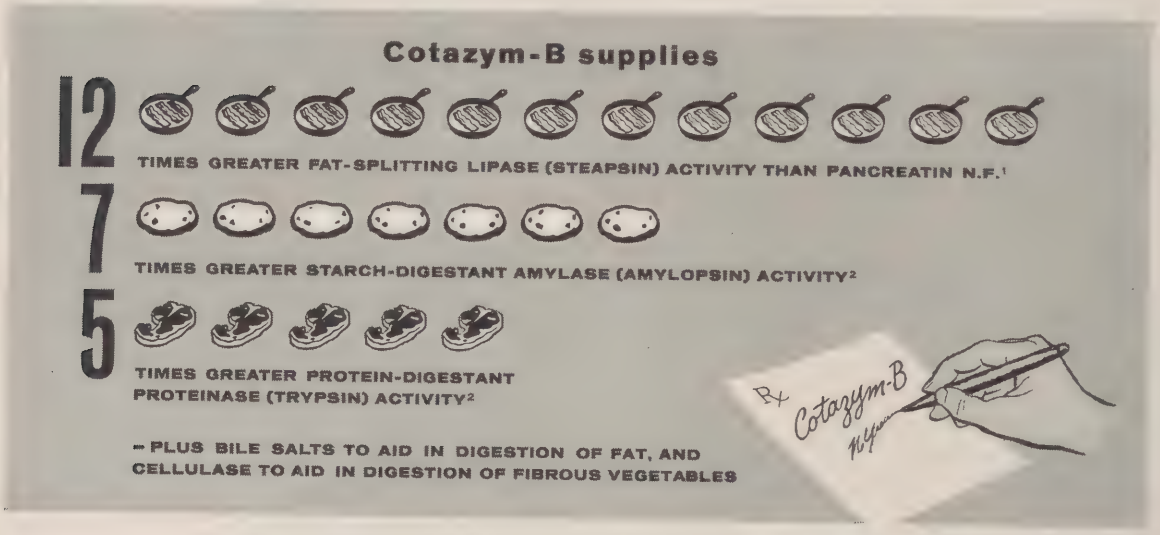
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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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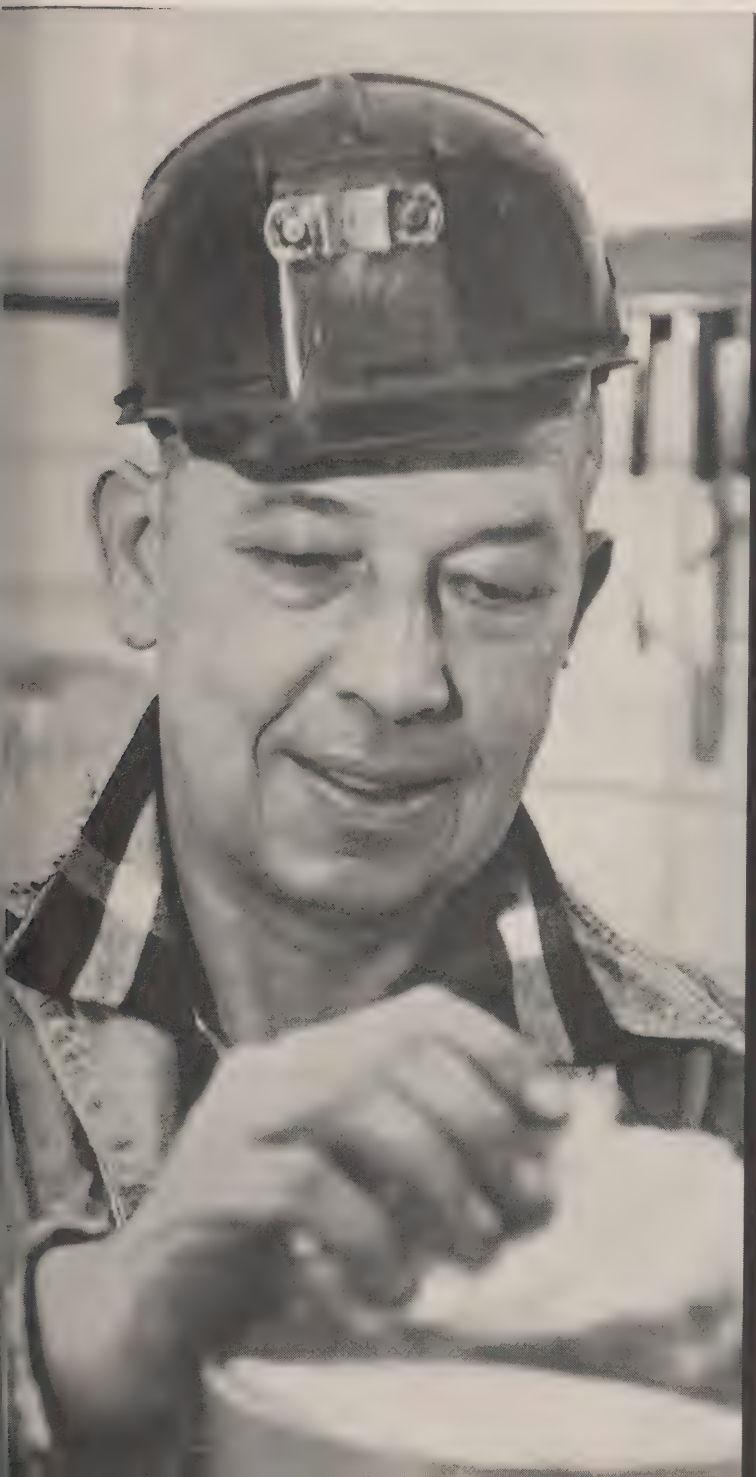
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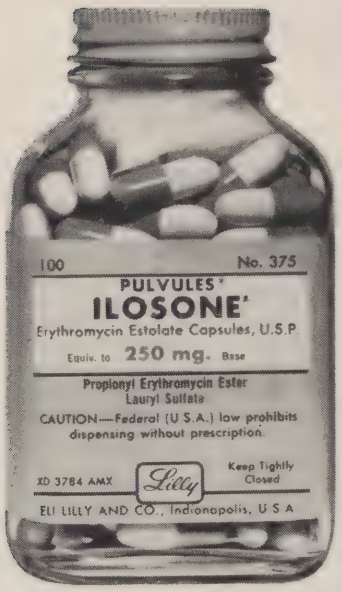


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The Journal
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VOLUME 58 May, 1962 NUMBER 5

CARUNCLE OR CARCINOMA?

BUFORD S. CHAPPELL, M. D.
Columbia, S. C.

The necessity for biopsy of all meatal lesions in the female has been stressed so often as not to require a new paper for emphasis. When, however, the lesions of caruncle and squamous cell carcinoma are placed side by side and made to include infiltration of the urethra by carcinoma of the bladder, then the necessity for biopsy is made more real and should include routine panendoscopy in the evaluation of these lesions.

In Figure 1-A can be seen a large caruncle in a 45 year old woman with mild symptoms referable to urination and a sense of fullness in her bladder. Seventeen months previously, she had fulguration of her caruncle by another urologist. The caruncle returned in a few weeks and has continued to grow and give symptoms. Radical excision was accomplished (Figure 1-B) but in a few weeks the caruncle had returned to its original size. Repeated fulgurations were necessary to effect a cure. The gross appearance of the lesions and its tendency to recurrence, caused us to be suspicious of a carcinoma, but careful study of the biopsy specimen failed to reveal any evidence of malignancy.

Figure 2-A shows the appearance of a squamous cell carcinoma of the urethra in a 63 year old married, multiparous female with a presenting symptom of "genito-urinary tract bleeding" of three or four months duration. Biopsy of the lesion showed squamous cell carcinoma of the urethra. Extirpation of almost the entire urethra (4 centimeters removed-1 centimeter left) (Figure 2-A) and



Figure 1-A
Caruncle of urethra

removal of the deep superficial nodes was accomplished in three separate operations. Pain and swelling of the legs and partial urinary incontinence resulted. The patient refused proposed surgery for the relief of her incontinence. Four years and ten months after the removal of her carcinoma, and when last heard from, she was free of evidence of recurrence of her carcinoma. The removed inguinal nodes showed no evidence of tumor and biopsy of the urethral stump three months after the initial surgery, showed no evidence of the tumor.

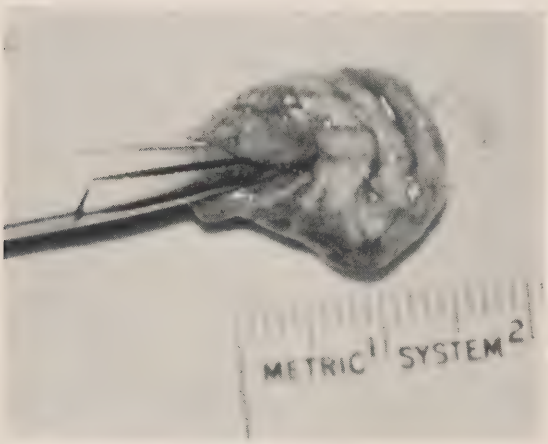


Figure 1-B
Cuff excised urethral caruncle

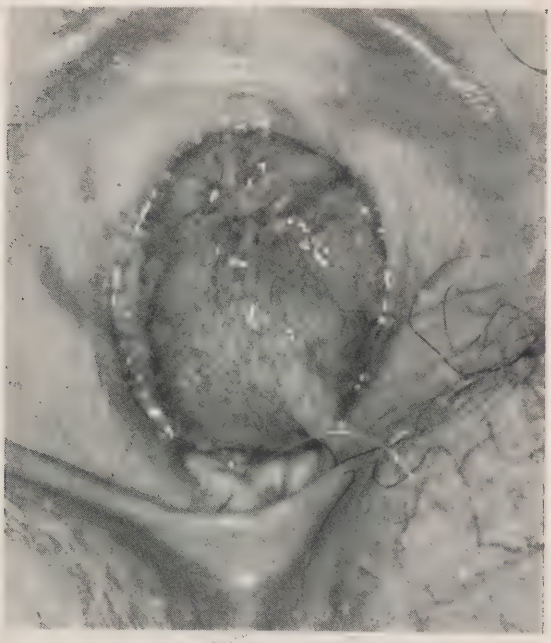


Figure 2-A
Squamous cell carcinoma of the urethra

Figure 3 shows a particularly innocuous appearing lesion of the external urethral meatus in a 77 year old, white, widowed female, whose chief complaints were difficulty in urination, severe frequency with scanty quantities of urine, nocturia and dysuria of three months duration. Her urethra was so tight and painful that local infiltration with novocaine was necessary before she could be catheterized and a 22F sound passed. Panendoscopy revealed a doughnut shaped tumor just inside and completely surrounding the internal urethral orifice. Most of the floor of the bladder was involved in a tumor with a distinctive papillary appearance. The urethra was red, granular, indurated and bled easily. Biopsy of the bladder tumor and a tag of tissue at the urethral meatus both demonstrated the same tumor: Grade III papillary carcinoma of the bladder. Radical surgery was not practical and the roentenologist advised against roentgen therapy. The patient died in one year. Several attempts at fulguration of the base after transurethral resection of all accessible tumor, gave doubtful benefits. Bleeding, difficulty in voiding, and urgency marked the later months of her life. Cicatricial cysto-urethritis with car-

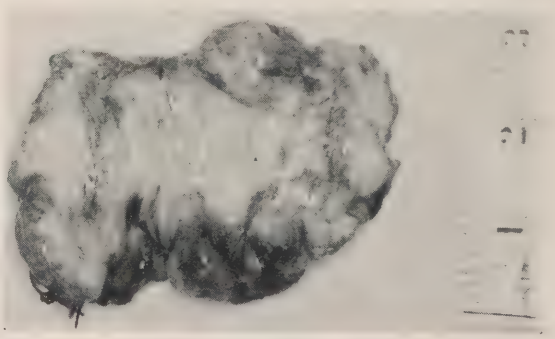


Figure 2-B
Excised lesion, squamous cell carcinoma of the urethra. The specimen has been opened and the dark border is the distal portion of the lesion.



Figure 3
Infiltration of the urethral meatus by papillary carcinoma of the bladder.

uncle formation was our initial impression. Panendoscopy gave us the diagnosis of carcinoma of the bladder and the suspcion that the urethra had been invaded by the bladder malignancy.

Summary

The need for biopsy of all lesions of the external urethral meatus in the female is emphasized and made more real when a caruncle that looks and behaves like a carcinoma, a squamous cell carcinoma of the urethra that looks like a caruncle, and carcinoma of the bladder that has invaded the urethra and looks like cicatricial urethritis with caruncle formation, are examined side by side. The need for routine panendoscopy is stated.

Buford S. Chappell
1420 Gregg St.
Columbia, S. C.

The Next Ten Years in Medicine—C. B. Esselstyn

New Engl J Med—Vol. 266:124 (Jan. 18) 1962

Several existing forces will have an influence over the next 10 years on medicine: (1) The public attitude toward the relative value of medical care. (2) Increasing public participation in voluntary health insurance. Medical care, which has become a public utility and, as such, in the years ahead will more and more come under the scrutiny of governmental agencies. (3) A change in the concept of health, which will lead to a much greater emphasis on preventive and rehabilitative services, together with home care. (4) Medical care, which will be influenced more and more by consumer groups. (5) The organization of medical services, which will tend to be more and more group practice associated with prepaid direct service plants. (6) The method of payment of services in the years ahead, which will emphasize the principle of payment of total health needs by a flat fee. (7) The leadership of organized medicine as it exists today, which will pay more attention to the membership or a competing organization will be founded.

Periodic Fever, an Entity. A Collection of 52 Cases—H. A. Reimann

Amer J Med Sci—Vol. 243:162 (Feb.) 1962

Periodic fever as described in 52 patients is an entity separate from periodic peritonitis, synovitis, neutropenia, and purpura. It is characterized by repetitive febrile episodes and autonomic disturbances in precise or irregular cycles of days, weeks, or months. It is hereditary, begins at any time of life, may last for decades with long spontaneous, temporary remissions, or may cease. The general health of the victims is not distrubed. Five died in a shocklike state and one from amyloidosis. The cause is unknown and treatment is ineffective. Because heredity, periodicity, cerebral dysrhythmia, and autonomic disturbances are common to the various periodic disorders, an interrelationship based on an obscure, innate, underlying rhythm is suggested. The site of origin may be in the brain, and the clinical form each of the disorders takes may depend upon inherited traits in individuals and in families. What incites episodes and controls their regular recurrence is unknown.

PAKISTAN MEDICINE

JANE L. BLAKELY

Medical College of South Carolina, Charleston, S. C.

On September 3, 1961, we arrived in Montgomery, West Pakistan, where we were to spend the next 13 weeks working side by side and under the direction of Dr. Reynolds Young in the Nancy Fulwood Hospital, a 90-bed hospital operated by the Associate Reformed Presbyterian Mission. Montgomery is a city of approximately 600,000 people, the "county seat" of a district which is part of the former Punjab, one of the richest agricultural areas in the East. Eighty percent of the total population of Pakistan still live in villages, and a great many people live in the rural villages around Montgomery. The hospital ministered to these villagers as well as to the "city folk". We often admitted patients who had been carried ten or more miles on a bed by four or five men. One woman, having severe convulsions almost constantly, arrived by bus from a village 30 miles away. We seldom made a trip to any village without bringing back at least one patient, his belongings and someone of his family to care for him. We sat in clinic six mornings a week unless we made a trip to a nearby village to hold a clinic. In the hospital clinic we often saw patients who had come from long distances to stay with relatives while they received treatment.

Most of these people had never been to school and can neither read nor write. Since we could not understand the language at first, we spent the time necessary for the nurse to obtain the history scrutinizing the faces of those who came to us. Some were hopeful—they belonged to individuals who had come for help believing that we could help them. Others expressed no hope—they belonged to individuals who had come as a last resort, having gone to every local *hakim* and pseudo-doctor without obtaining any relief. They had no faith that we could help and indeed often the disease process had progressed beyond our knowledge or skill to battle it.

We were fortunate to fly to Pakistan with a returning missionary who spent much of the 40-hour trip (including time-out for plane trouble) telling us of the people of Pakistan, their lives, and their customs. Knowing how necessary it is to understand people and their customs to be able to understand their reactions to illness, we had already made some effort to learn as much as possible about the country, its people, and their religion. Even in three months in the country we never did learn enough, however. We came to have some realization of how nearly impossible it is to convey the concept of long term therapy for anything—iron for anemia, bed rest for rheumatic fever, chemotherapy for tuberculosis—how nearly impossible to obtain an adequate history from people who have little concept of time. We came to understand what little sense it makes to people who have to eke out an existence to talk to them about the prevention of disease.

To maintain an attitude of objective observation we found impossible, for we soon found ourselves personally involved in the work of the hospital and the mission because of the limited medical force on duty and the illness of the Anglo-Indian doctor doing most of the women's work. Because the custom of purdah still practiced by many of the people forbids a woman to be seen by any man other than her husband, it was necessary for us to do much of the obstetrical work. Since we had not the knowledge to handle many of the complicated cases, Dr. Young often stood in the next room and called the maneuvers through the doorway.

Smith Kline and French Foreign Fellow in the Nancy Fulwood Hospital, Montgomery, West Pakistan, sponsored by Dr. Reynolds Young, formerly of Due West, S. C. Date: Sept. 1 - Nov. 29, 1961. Awarded by the Association of American Medical Colleges.

Many uncomplicated deliveries are done in the homes by the class in midwifery of the nursing school maintained in conjunction with the hospital. Consequently most of the obstetrical cases which reach the hospital are complicated cases. The first seven babies we delivered were stillborn. We have no idea of the true maternal or fetal mortality rate in Pakistan. In the city of Montgomery a small Red Cross Maternity Hospital is doing a commendable job holding pre-natal clinics and well-baby clinics. We helped judge their annual Baby Show and saw the fruits of their labor—healthy children and proud mothers—an unusual sight in the country. This effort is only a drop in the bucket of complacency and ignorance, however. Many more such clinics are needed.

Ignorance and Untrained Nurses

Most babies are delivered by self-styled, untrained mid-wives called *dies*. We were called one afternoon to a well-to-do home for a delivery which we assumed was to be abnormal because the messenger asked for a doctor. On examining the patient we found a prolapsed cord and on close questioning found that the cord had indeed been pulled all the way out by the *die* and then stuffed back into the cervix. Needless to say the *die* had gone when the family sent for us. We delivered a stillborn some two hours later and had to carry out a manual removal of the placenta.

One day in the clinic we saw a young girl who was 18 weeks pregnant and had been bleeding intermittently for six weeks. Some "doctor" had told her that she had a placenta praevia and she had had 20 subsequent pelvic examinations by others. Like many of the people she had been making the rounds of doctors looking for help and never being quite satisfied.

Post-partum tetanus is not at all uncommon because of the practice of putting a plug mixed of a greasy material, dirt, and buffalo dung into the vagina at the onset of labor to aid in dilating the cervix. The cure rate when such tetanus does develop is not good because the family waits so long to bring the patient to a doctor.

Neonatal tetanus is also fairly common. One child was brought to us five to six days after delivery having spasms involving his face and upper extremities. We did all we could except tracheotomy which the family refused to let us perform. The family decided to take the child home to die (since it is difficult to transport a dead body in the country because of its rapid decomposition, most of the patients were taken home if death seemed inevitable). Two weeks later to our amazement we looked up to see the child which the family had brought to us so that we might see how well the child had recovered. This and other experiences taught us not to be surprised when the apparently impossible happened before our eyes.

We observed three deliveries in which cranioclasis had to be performed on the fetus because a mother with a contracted pelvis had been allowed to labor three or four days. In each case the fetus was dead when the mother reached the hospital. Had the women been brought to the hospital at the onset of labor it might have been possible to extract a living child by cesarian section. One day we performed two sections. We delivered a fine baby boy of a woman who had had a previous section for a contracted pelvis and then delivered a set of twins, boy and girl, from a primagravida whose uterus had a five cm necrotic area in the left wall as a result of prolonged obstructed labor. The mother of the twins had the only case of post-operative ileus we saw during our entire stay. Fortunately both mothers and all three children survived in good shape.

We were surprised that so few of our operative patients developed complications since we had no drainage tubes to use post-operatively and very few fluids for intravenous use, so that patients were usually started on oral liquids by the end of the first post-operative day.

In spite of the fact that overpopulation plagues Pakistan, as it does most Eastern countries, the most frequent problems brought

to the clinic resulted from sterility and infertility. According to the custom of the country a man's virility is measured by the number of sons he has. Since polygamy is legal a man keeps marrying until he gets a wife who does give him a son. The unhappy wives who did not have a son soon after their marriage or after a number of years came to us for treatment. Many of them were hopelessly scarred with pelvic inflammatory disease. We could not determine the cause of sterility in some and could not persuade the husband to come for examination. We performed a myomectomy on one nulligravida married 14 years only to find both tubes scarred and sealed by salpingitis and multiple fibromyomata in the uterus. She had begged us by word and look to help her. How sad to send her home for she almost certainly would be "put away" by her husband.

Amebiasis was such a common disease that everyone who came to the clinic complaining of diarrhea, abdominal pain and excess gas was given anti-ameba treatment first of all. Most responded. We had two interesting cases of amebic abscess involving the liver. The first was in a man about 31 years old who was carried into the hospital one day with a raging fever. He looked quite ill and on examining him we found that there was fullness over his right lower rib cage. He had a history of having had chronic diarrhea in the past. His diaphragm was high and fixed on the right by x-ray examination. Aspiration was performed and 775 ml. greenish-yellow material was obtained. Six days later a second aspiration attempt produced no material. The man was treated with emetine and made a good recovery. Two months after admission he was free of symptoms and able to do his work.

The second case occurred in a 35 year old man who came in with epigastric pain. He also had fever and looked toxic. Aspiration of the liver was attempted unsuccessfully. Two days after admission he began coughing up copious amounts of typical "anchovy paste" sputum. X-ray examination showed "tenting" of the diaphragm on the right with some infiltration of the lower lobe of the right lung. This man was also treated with emetine. He refused any attempt at drainage of the abscess and finally ran away from the hospital. He had stopped coughing up sputum and appeared much improved. An x-ray film taken shortly before he left the hospital showed marked improvement in the lung fields and not such marked tenting of the diaphragm.

Tuberculosis A Major Problem

Tuberculosis is another major problem of Pakistan. There were 20 isolation beds in the Nancy Fulwood Hospital reserved for open cases of tuberculosis. These were never enough. Many patients had to be treated on an out-patient basis. One hospital that we visited admitted no contagious cases of tubermulosis, but only cases of tuberculosis of the abdomen which required surgical intervention for partial or complete obstruction. One case which taught us a great deal was that of an 18 year old girl who came to us complaining of amenorrhea of seven months duration. On questioning we learned that all of her hair had fallen out two months prior to admission, but we could get no history of an illness or febrile episode of any kind. We examined her pelvis first and finding her pelvic organs to be normal turned to the lungs. Here we found the "sticky" rales we had come to recognize as characteristic of tuberculosis. She was being treated with isoniazid and streptomycin when we left.

Tuberculosis in Pakistan carries a high mortality rate: because (1) the people wait too long to see a doctor, (2) they often will not keep up the long-term drug therapy, and (3) the disease appears to be very virulent in the Pakistani people. One of the major contributions we were able to make was helping to conduct a mass survey minature x-ray program. A mobile x-ray unit recently brought into the country by the United Christian Hospital, Lahore, in cooperation with the West Pakistan Christian Medical Association was sent out into villages and pictures taken of as many people as would come for a very small fee. Some 2200 x-ray films were taken in our series. These were read and categorized ac-

cording to the AMA system of classification. When our three months were up, we had read 1500 of the films, found 243 cases of suspected tuberculosis and 15 cases of definite tuberculosis. A follow-up program of further testing of those with suspected disease and treatment of definite cases has already begun. It is hoped that this mobile unit will be of great use in conducting such surveys throughout the country. It is believed that this type of survey and follow-up program offers the first real hope for control of tuberculosis in this country and others like it.

A condition which we encountered frequently particularly in women was anemia, often of a profound degree. The chief factors contributing to this in the majority of cases appeared to us to be multiparity and malnutrition. The latter is intensified in the women because the custom is for the women and children to eat whatever is left after the men of the household are satisfied. The diet of the average person is at best rather poor, with a definite lack of meat and iron-containing fresh vegetables.

Profound Anemia

One woman was brought to us early one morning and died even as we were examining her. She was 5½ months pregnant and in terminal congestive heart failure. Her nail beds and mucous membranes as well as her conjunctivae were extremely pale. Another woman, 5½ months pregnant was sent to us in early congestive heart failure. Her hemoglobin was 3 Gm. We nursed another post-partum patient for two months before she demanded release. Her hemoglobin on admission was 1.5 Gm. and dropped to 0.9 Gm. the week after admission. She was admitted with infection and congestive heart failure. Her infection cleared and she was digitalized and treated with iron. She was much improved when she demanded release. She will probably come back to the hospital with her next pregnancy in congestive failure again.

A great scourge on the country of Pakistan is blindness. Cataracts, glaucoma, and trachoma are the main conditions that contribute to blindness. No specific work with the blind is carried on in Montgomery at present for lack of time and training. However, we did visit the Mission hospital at Taxila where approximately 300 cataract operations are performed daily during the eye season. The patients are housed in open sheds built on the hospital grounds and in tents put up temporarily. Thousands find their way to this center each year to receive their sight.

Rawalpindi Leprosarium

On the same trip that we saw the work at Taxila we walked through the grounds of the leprosarium at Rawalpindi. Here live 135 patients, each in his own little hut with a plot of ground to work. Most of the patients had some chickens in the yard from which they gained some income by selling eggs. Most of the patients in this colony were badly disfigured and are being kept there for social reasons and to help them care for themselves. Some plans for the establishment of an operating room where some reconstructive work may be done on some of the patients are being considered. This colony is directed by a young girl with only a medical technologist's degree who has devoted her life to working with these people. A doctor from Taxila, 30 miles away goes over to the colony and makes rounds once a week. Active cases of leprosy are still being admitted; one just the week before we visited the colony. We did not see any case of leprosy further south around the Montgomery area.

Perhaps one of the most neglected groups in Pakistan is her children. Thousands of children play and run in the streets and fields with very little effort made to teach or discipline them. Two Scottish nurses have set up a children's ward in a mission hospital in Guijarat where children who must remain immobilized for long periods of time are taught to read and write and sing. This ward with the happy faces of children who now have faith in spite of crippling disease is an inspiration to all who visit.

At the hospital in Montgomery we became expert at assisting with operations such as a

suprapubic cystotomy for removal of bladder stones, a frequent occurrence especially in young children. Perhaps the temperature of the country which causes more sweating and a decreased urinary output because of the sweating, and the Pakistani's small consumption of water cause a superconcentration of the urine. At any rate there seemed to us to be a very high incidence of bladder stones. We did many suprapubic prostatectomies in elderly men. This operation, fraught with many hazards when done in this country, is doubly dangerous in Montgomery where there is no facility for measuring urea nitrogen of the blood or for evaluating kidney function fully.

We had hoped to assist in setting up some basic chemistry determinations in the laboratory at the hospital, but were prevented by the failure of arrival of equipment and the resignation of the native technician. We ended up doing most of the hemoglobin determinations and urine examinations for a period of about two months until a new technician could complete her training.

One of our privileges was that of lecturing to the nursing classes in anatomy and medicine and surgery. These lectures were given in English to give the nurses more training in understanding and writing that language because all of the examinations given by the government are given in English. Many of our students find it difficult to pass these examinations not so much because of ignorance of the subject matter as of the foreign language.

One of the great joys of our Pakistan experience was that of visiting in Pakistani homes and talking with people everywhere we went. Many times we found ourselves filled with admiration for men and women of vision who are concious of their country's need, of her people's need, and are working to overcome the greed and graft of those who would prevent her growth and development. We are profoundly grateful to Smith Kline and French for making possible these experiences.

The Diagnosis and Treatment of Carcinoma of the Prostate: Some Useful and Practical Suggestions—L. P. Thackston, N. C. Price and L. P. Thackston, Jr., (Orangeburg)

J Int Coll Surg 36:315-322, Sept. 1961

This paper compares the results obtained in the Urological Institute from July 1, 1927, to date, with the results published from recognized clinics in the United States and abroad. It was found that the results closely parallel each other, and only minor differences were noted. The importance of the diagnostic point of hemorrhage from the prostatic fossa after the passage of several months following a benign adenectomy in the diagnosis of cancer in the prostate was brought out. Also mentioned were some suggestions as to modification of the technique of retropubic prostatectomy for carcinoma of the prostate. The hope was expressed for improvement in diagnosis, and a break-through in the treatment of this severe and common disease.

Influence of Modern Footwear on Foot Disabilities—M. Naomi Wing

Med J Aust—Vol. 2:818 (Nov. 18) 1961

It has become the fashion to wear shoes which offer little support and to have stiletto heels of excessive height, with an extremely arched shank. If the shank is made with poor steel, there is much ligamentous strain. The sudden change to flat shoes at the end of the day also irritates the ligaments. At present no matter where one inquires, whether in the United States of America, Canada, Great Britain, Europe, Africa, or Australia, it is quite impossible to purchase a dress shoe free of the Italian influence of the excessively pointed toe and thin heel. It is the duty of the physician to become more foot conscious, and to observe the gait of his patients and the type of shoes they wear. He should try to relate these to their constant complaints of fatigue and their general inability to adjust themselves to the demands of modern living.

MANAGEMENT OF HUMAN LEUKEMIAS AND HODGKIN'S DISEASE WITH DOPAN (URACIL MUSTARD)

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In a study of the antitumor effects of the nitrogen mustard, Dopan, in both animals and man, 15 clinical reports have been cited.[14] In the present communication 13 additional clinical studies support the claims of this promising uracil mustard in the management of Hodgkin's disease and chronic leukemias.

Hodgkin's Disease. Ivanova[2] reported on long-term results with Dopan in 110 patients with Hodgkin's disease: 17 of 19 in Stage II of the disease had good responses; 65 in Stage III showed some good improvement, but one-third needed x-ray therapy also; 26 in Stage IV were largely resistant; of the 93 patients who responded 53 were alive at the time of reporting: 8 of Stage II and 10 of Stage III have lived for more than 3 years and 2 for over 4 years. Shanbrom and associates have released 3 reports on the results of Dopan therapy: in the first[10] they described good but brief improvement in 23 patients, with only mild side effects; in an abstract[11] they listed the response of 25 patients with Hodgkin's disease as good, along with 9 lymphosarcoma, 2 giant follicular lymphoma, 4 polycythemia vera, and 13 chronic granulocytic leukemia; in a third report[12] they noted 21 subjective and 16 objective responses in 30 patients with Hodgkin's disease, and the drug was well tolerated by the 130 patients with malignant blood disorders, as well as those with solid tumors, although they tabulated 41 cases of nausea, 12 of pruritis, 7 of nervous irritability, etc. Semina[9] recorded 9 complete and 15 partial remissions which lasted from 4 to 24 months in 33 patients receiving a combination of Dopan and x-ray therapy. Blokhin[1] induced 15 clinical responses in 28 patients who were administered Dopan. Morozova[7] alternated the N-mustard with irradiation in 20 patients to secure 13 remissions; patients in stages II and III had good remissions extending from 6 to 14 months; nausea or vomiting or both occurred in 8 cases. Kennedy and Theologides[4,5] in 2 reports observed 8 subjective and 8 objective improvements in 14 cases of Hodgkin's disease in stage III. In a preliminary release Lane, *et al*,[6] listed 3 of 6 patients as responding objectively to Dopan. Spurr and Hayes[13] induced subjective and objective improvement which lasted 3 months in one patient. Perevodchikova[8] noted that both Dopan and Sarkolysin were effective in Hodgkin's disease, but he gave few details on the treatment.

Chronic Lymphocytic Leukemia. Kennedy and Theologides have released 3 publications on the management of chronic lymphocytic leukemia with Dopan: in 1960[3] they obtained objective improvement in 9 of 15 patients, and they observed less side effects when the drug was administered orally; in a second paper[4] they listed 15 objective and 12 subjective responses in 19 patients for the following periods: 3 for less than 3 months, 5 for 4-6 months, 3 for 7-12 months, and 4 for longer than 12 months; in a third report[5] they recorded 15 objective and 12 subjective improvements in 20 cases. Shanbrom, *et al*,[10] in 1959 observed that chronic leukemias (1 chronic lymphoid) gave him his best responses with Dopan; in a second report[11] on 17 cases they described similar results, but again stated no numbers of those who were improved; in a third release[12] they tabulated 14 subjective and objective improvements in 21 cases. Spurr and Hayes[13] described 5 subjective and objective responses extending to 6 months in 7 cases.

Chronic Granulocytic Leukemia. Shanbrom, *et al*,[10, 11, 12] included chronic granulocytic

leukemia in their 3 publications on Dopan: in 1959 they recorded good benefit in 14 patients, and the next year they counted 11 subjective and objective improvements in 13 cases. Blokhin[1] induced clinical remissions in 3 of 4 patients, while Lane, *et al*,[6] described an objective response in one patient.

Acute Leukemia. Kennedy and Theologides[4, 5] failed to observe any improvement in a patient with subacute lymphocytic leukemia after treatment with Dopan, while Shanbrom,[12] noted subjective improvement in only one of five patients with acute granulocytic leukemia.

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Ipecac: A Slow or Fast Emetic? — W. O. Robertson

Amer J Dis Child—Vol. 103:136 (Feb.) 1962

In 214 children, syrup of ipecac took an average of 18.7 minutes to induce emesis. Eighty-eight per cent of the children vomited in 30 minutes or less. Thus, syrup of ipecac can no longer be referred to as a "slow-acting" emetic. Precise information for 150 of these children indicated that more than an hour (average 68.7 minutes) was consumed in reaching the Emergency Room. Therefore, the postulated disadvantage of ipecac's delay in inducing emesis would seem of secondary or negligible importance compared with delays in recognition or transit. Administration of 20 cc. of syrup of ipecac should be regarded as the treatment of choice in managing poisonings wherein evacuation of the stomach contents is desirable and not specifically contra-indicated. The fluid extract form is to be avoided.

Hazards of Unnecessary Blood Transfusions— —D. J. Fernbach

Anesth Analg—Vol. 40:677 (Nov.-Dec.) 1961

Increasing use of blood transfusions results in additional complications and rising mortality. Hepatitis, isoimmunization, circulatory overload, and hemolytic, febrile, and urticarial reactions cannot always be prevented. Air embolism, identification errors, and mismatches still occur. Incidence can be further reduced by: (A) Elimination of unnecessary transfusions, such as "cosmetic-transfusion," "tonic-transfusion," "slight-anemia-transfusion." Use transfusions to improve oxygen carrying hemoglobin level and blood volume only if deficiency imposes hazards worse than transfusion hazards. (B) Improved matching: (1) Include Coombs' technique. (2) Match donor versus donor for multiple transfusions. (C) Consideration of the patient as a prospect donor for himself (autotransfusion) for elective procedures.

DR. TUCKER HARRIS AND COLONIAL PHYSICIANS

F. EUGENE ZEMP, M. D.
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This was an exciting period in American History. Fervor ran high in the American Colonies. There was a sense of freedom in the air. The Revolution was soon to take place.

For one to become a physician at this time, he had to apprentice himself for a period of years to a practicing physician or, if he was more ambitious or better endowed financially, he went abroad to obtain the M. D. degree from a European university. There were two brilliant young men from Philadelphia, John Morgan and William Shippen, Jr. who had studied medicine at the University of Edinburgh between 1760 and 1762. While there, they talked about the need of a school of medicine in the American Colonies and on their return to America, persuaded the Trustees of the College and Academy of Philadelphia, which later became the University of Pennsylvania, to start such a school. They had very little difficulty, because five of the most influential members of the Board of Trustees were physicians. On May 3, 1765, John Morgan was elected Professor of the Theory and Practice of Physic; four months later, his friend Shippen was elected Professor of Anatomy and Surgery, and that autumn they began their lectures. Closely associated with them in their project was Dr. Thomas Bond, a trustee of the College and Chief Physician of the Pennsylvania Hospital, which was founded in 1751 through the joint efforts of Dr. Bond and Benjamin Franklin. Dr. Bond commenced a course of clinical lectures in the hospital at the beginning of the second year of the work of the new medical school of the College. In 1768, Adam Kuhn, a native of Germantown, pupil of Linnaeus in Upsala, doctor of medicine from Edinburgh, became professor of Materia Medica and Botany; finally in 1769, Benjamin Rush after taking his degree in Edinburgh was made professor of chemistry. At this time, Dr. Morgan wrote that the original plan which he had presented to the College for the institution of a medical school had been completed.

The distinction of the first faculty of the University of Pennsylvania Medical School is universally conceded. Morgan's brilliance as a youth is attested by his membership in the Royal Society of London, the College of Physicians of Edinburgh, and in the Academy of Surgery of Paris. During the Revolution he held the office of Medical Director-General of the American forces for more than a year. He died in 1789 at the age of 54. Shippen succeeded Morgan as Medical Director-General of the American Army. After the War, he continued his services as professor in the university to a total of forty three years; the reputation of his teaching increased with years and he has been called the American Sydenham. His writing on chorea infantum, dengue fever, thermal fever, the Philadelphia epidemic of yellow fever and on insanity, show his powers of clinical study. He also investigated medicine among the Indians of North America and wrote an essay on this. He was a member of the congress which signed the Declaration of Independence and he served as Surgeon-General of the middle section of the American Revolutionary forces. During his whole life, he took a most active part in the intellectual life of his day.

About this same period of time, there was also a group of distinguished physicians in Charleston, S. C. One of them, David Ramsay, who had received his Degree of M. B. from the new College in Philadelphia, was said to be the first graduate of the Medical School.

Read before the Columbia Medical Club September 21, 1959.

Others were Dr. Alexander Baron, native of Scotland, a graduate of the Medical School of the University of Edinburgh and Dr. Peter Fayssoux, who was one of the leading spirits in the formation of the Medical Society of South Carolina and later its first President. He was also a member of the South Carolina State Legislature, active in national affairs and formation of the Federal Government. All had been practicing in Charleston since 1783. Also practicing there about this time were Drs. Andrew Turnbull, Tucker Harris, Robert Wilson, George Logan, James Lynah, Richard Savage, Isaac Chanler, John Budd and several others.

One night they gathered at the home of Dr. Peter Fayssoux on the corner of Tradd and Friend Sts. (now Legare) to form the Medical Society of South Carolina. They thought by doing so, it would tend to improve the science of medicine and promote liberality in the profession and harmony among the practitioners of the city. Several days later they had another meeting for the purpose of starting a Dispensary. A few weeks later, rules were adopted and Dr. Peter Fayssoux was elected president and Dr. Alexander Baron, vice president, Dr. Tucker Harris, secretary and Dr. David Ramsay, Treasurer. A library was founded in November 1793 by the members and they petitioned the State legislature for an act of incorporation. They also petitioned for power to regulate practice and regulate drugs. On May 10, 1794, the charter of the Medical Society was granted, but the desired delegation of the power of regulation of practice and the inspection of drugs was not included in the act. A wide variety of activities were undertaken by the Medical Society and at the request of the city authorities, they advised the best method of preventing the introduction and spread of contagious diseases in the city. In 1801, the city council requested the medical society to constitute itself into a board of health which functioned for 7 years until its duties were taken over by the city commission of health.

Dr. Tucker Harris was born in Charleston, S. C. in the year 1747. While a youth, he was remarked for his prudent conduct and assiduity; and discovering his love of medicine, his parents were induced, at a suitable age, to place him with Dr. Lionel Chalmers, a physician of great respectability and distinguished abilities. Under such a preceptor, he made a flattering progress in the acquisition of knowledge and was complimented by Dr. Chalmers



DR. TUCKER HARRIS

for his correctness and acuteness of observation. The American medical universities were still in their infancy and after acquiring a proficiency in pharmacy, Dr. Harris went to Edinburgh to continue his studies. There he diligently attended three courses of lectures of the most illustrious Professors of this age, among whom was the father of modern physic, Dr. Cullen and Dr. Gregory. While he was there he wrote and defended his inaugural thesis "De Cholera Spontanea", dedicating it to Dr. Lionel Chalmers and Dr. John Gregory. He received from Edinburgh the degree of Doctor of Medicine June 12, 1771.

While at Edinburgh, he boarded with a Mrs. Boston after he had been introduced by Dr.

Isaac Chanler. He fell in love with her daughter Christiana and on July 11, 1771 he was married in Falkirk, Scotland by her brother. This marriage yielded him eight daughters. Of these Henrietta Simpson Harris was married to Dr. Samuel Wilson and Sara Harris was the third wife to Captain James Simons.

Dr. Harris returned to Charleston in 1771 to practice and commenced under most favorable circumstances. His talents were recommended to the community by his friends and precepter, Dr. Lionel Chalmers, who a few years later died. He was worthy in every respect of the patronage he received. The Revolutionary War came along and his patriotic ardour induced him with alacrity to engage in the cause of liberty. He served as a hospital surgeon in the garrison and occasionally in camp. On restoration of peace, he resumed his practice with increased rapidity. From 1783 to 1786 he was connected in partnership with the venerable Dr. David Oliphant, but most of the time, in the latter part of his years he conducted his professional duties himself. Friendly with the other eminent physicians who had come to Charleston, he helped in the formation of the South Carolina Medical Society and was president from 1796 to 1797.

As a physician, Dr. Harris was very skilful. With a heart of great sensibility, it was his happy talent to engage the esteem and affection of his patients. The correctness of his skill and long experience aided him in this unusual share of success.

As a friend, Dr. Harris was sincere, kind and undeviating. From him the cause of religion received his liberal support. His charity was ever active and he was very sympathetic to widows and orphans. He was also a fond and affectionate husband and loved his children. However, his wife's long and painful illness caused him to withdraw from the cares and anxiety of his profession and her death, after 47 years of amiable partnership, left an irreparable chasm.

Dr. Harris possessed a good constitution and had good health all his life, except for camp or hospital fever which he contracted while in the line of his duty, during the Revolutionary War. Due to his peaceful and regular life he lived to a healthy old age until he became subject to frequent paroxysms of visceral disease which lead to chronic diarrhea and absorbed his strength. He died July 6, 1821 at the age of 74. Dr. Harris being averse to pomp and pageantry, requested that he be attended at his graveside by his nearest male relatives only. He was buried in the family burial place at St. Paul's Church in Charleston.

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THE PSYCHOLOGIC CARE OF CHILDREN

R. M. POLLITZER, M. D.
Greenville, S. C.

From long experience the writer draws some observations on the management of the emotional processes of children.

IT has been said that children are our most precious possession; also that the world moves forward on the feet of children. These are fine sounding words, but even so to most people they are only words. At the outset let me admit that the care and the understanding of children is not always an easy task, and at times their rearing may be not only troublesome, but difficult.

Some 40 or 50 years ago, the specialty of pediatrics consisted largely of infant feeding, and the treatment of acute and chronic diseases. We paid little or no attention to other than the child's body. Child psychology is of recent growth. Of course this branch of knowledge is not an exact science even yet, and probably never will be as definite and standardized as say, physics or chemistry, even though some modern procedures as the electroencephalogram, and biological chemistry have been of assistance, but in a general way, much of psychology is a matter of getting a history, then observing the individual and his environment. Of course there is much literature on the subject and we have come a long way.

For not so long ago, the child was considered merely a little adult, and further and most unfortunately for a long time, through many ages it was firmly believed that he had inherent sin, and that frequent corporal punishment was necessary. Our grandparents and even a few of our parents had this belief. In some churches today it is thought that the infant is born wicked, and certain ceremonies must be carried out to save him from damnation; but by and large we have made some progress in our understanding and psychological care of the child. That is, at long last we have passed through the Dark Ages. Actually we are getting back to the teachings of the ancient Greeks. They divided man into two portions, the soma or body, and the psyche, meaning the soul, mind or spirit.

Now the psychologists and psychiatrists have made us aware that since the child is more than just body, we should do more than treat illnesses of the body, and prevent them. But many of the psychological ills can also be treated and the majority by proper handling prevented.

It is not difficult to understand why in medieval times, not only children, but the mind and all the beauties on earth were neglected, for it was believed implicitly that our time here was so short, that we should concentrate on our existence in Paradise. The Greeks and the Renaissance tried to shatter such ideas, but most people still clung to the older dogma and so children were whipped, beaten and had frequent corporal punishment. In the older novels we find many examples of that.

But today we know that children are not born bad. We are sure that they come into this world with certain bodily and mental characteristics, and while to a large extent they have limits or even inborn errors or some deformities, because of certain abnormal genes, yet they are to a large extent the product of their environment, and the average normal child can be hurt or helped by the way he is reared. That is, a parent, the parents, a teacher or the teachers are of great importance in child rearing, and have unlimited opportunities in molding the child's character.

A century or more ago Froebel, a German,

and Pestalozzi, a Swiss, did much in writing on education, even though little of their teachings is now of much value, but they were pioneers. Within our time John Dewey, an American, who was highly educated, lectured and taught in various places. He had a long life and radically changed our ideas on education. He originated what was called Progressive Education. As happens with most pioneers he probably went too far, but at least he overcame the Spartan or Prussian theories of rigidity, and made life more pleasant in the school-room. While undoubtedly some of his ideas will be retained, already we know that much must be discarded. This in a way is analogous to the effect that Sigmund Freud has had on psychiatry. A great deal of his teachings have already been done away with, but he contributed much to our knowledge and considerable of his work will remain.

This in a way may seem to be wandering from child psychology, but what we teach to, or do with the child derives from our ideas about the child and about his place in our civilization. For instance if we believe that the child can be made to become a member of our group, and to be a civilized and law abiding member of society, then it is necessary by word and example to instill in him the knowledge that certain things are done by the group, and that others are not acceptable. No one need wait until the little one goes to kindergarten or school. Too often today training is neglected in the home. This is largely so because in our modern society so many mothers work, and a large number have so much of their time taken up with social activities. But that is not to say that there are not many mothers who do give a child loving care, and spend considerable time on his rearing. Of course it is always possible for a mother to make her child too dependent, which perhaps is almost as bad as neglect.

Within the past 25 or 35 years many books on child rearing have appeared that are of great help to doctors and some to parents, and also a number have been written specifically for younger children as well as adolescents. But in a different vein is a work entitled *Child Psychiatry* by Dr. Leo Kanner, which appeared almost 30 years ago. It is comprehensive and scientific, but distinctly for the doctor, covering normal as well as abnormal aspects. A later small volume, entitled *Psychologic Care During Infancy And Childhood* is by Drs. Ruth M. Bakwin and Harry Bakwin. This was first published in 1942. It deals entirely with the normal child, though it discusses some of his problems. It is intended for the doctor who sees all ages in the home, office, or hospital.

A series of volumes written primarily for parents and children themselves, and the latest one for adolescents, is by Dr. Frank Howard Richardson. These volumes are small in size, and written in an easy conversational style. Not only children can gain much by reading some of them, but student and camp councilors, as well as parents may find much of value in them.

But in general if one will realize that an infant is the most helpless of all animals, that he needs constant care and attention during the first year, and after that much guidance is essential, he will make a good beginning in understanding the child and his needs. When we consider how much has to be learned about people and surroundings in this period, and then on up to school and to college, it is no wonder that at times the child is bewildered, frequently hard to get along with and often discouraged and dismayed.

But early in life at some time during the first year, various problems of a psychologic nature begin to appear. This is by no means unusual or surprising, and if the parents are aware that they are present, and know how to deal with them patiently, firmly and wisely, there should be no great difficulty. It would take much time and space to list the difficulties in infant and child rearing, even assuming that the little one is normal, but in general, they come under the heading of emotional problems, and those natural to development. Perhaps difficulties in feeding, in sleeping, toilet training, playing with other children, and learning that other people have rights too, are among the most important, though there are a host of others. But each difficulty must

be handled promptly and wisely without anger or excitement, regardless of how much the mother may be upset by her "little darling" at the time. There can never be a set of rules for parents or doctors to cover all types of bad behavior and the correct steps to take to prevent or cure them. However regardlesss of much that has been said and written, it is highly questionable that corporal punishment at any time is necessary, except when the little one does something purposely injurious to someone, to himself or to property, and of course no child should be permitted to endanger his life by some action that one knows is highly dangerous, as getting out in the road, where automobiles pass, or sitting on a railroad track. But patience and perseverance, along with some explanation, when the little one is old enough to understand can accomplish much. Above all, whether at home or in school, it should be clearly understood that both excessive dominance and permissiveness are equally bad. Many parents go from one extreme to the other.

Adolescence really deserves a whole book in itself. The child enters on a period in which he finds himself or herself a different person, and not understanding what is happening. A parent who will take time can do much that will help. But it should be told to all parents by doctors, teachers and others that until the child is grown it is their privilege and duty to direct the child. After the age of 13, 14 or 15 is reached it is already too late to admonish or scold the boy or girl for some act committed against society, regardless of whether it be theft, injury or something in the realm of sex. For the mother or father has already had her or his chance, and let it go by.

When one talks or writes of juvenile delinquency, he should question whether the fault be in the parents rather than in the child. Further one wonders often whether children are worse than their parents; the great Greek playwright Aristophanes, about 400 B. C. commented on the faults of the young people of his day.

In conclusion much that has been written here may be summarized by stating, without much likelihood of contradiction, that all babies and children must learn to obey, and that they are entitled to love and security and guidance and especially that they should have happiness. In our United States, in the Declaration of Independence, it was stated that each person is entitled to the pursuit of happiness. Parents, in so far as they can should see that their children achieve it. Further all parents and teachers ought to realize that education in itself while necessary, is not all that is essential to the child's successful development.

Gold therapy in rheumatoid arthritis — The Research Sub-Committee of the Empire Rheumatism Council

Ann Rheum Dis—20:315 (Dec.) 1961

Follow-up studies for 30 months from the onset of treatment were made on 159 outpatients (aged 20 to 64 years) who had had active rheumatoid arthritis for from 1 to 5 years, and who had received gold salts in a 5-month course (one injection every week for 20 weeks). Weekly injections of 50 mg. of sodium aurothiomalate (Myochrysine), (a total of 1 gm.) was given to 77 patients (gold series), and the 82 patients in the control series received 0.5 mcg. of the same substance every week (total of 0.01 mg.) Considerable improvement by all criteria except radiological examination was seen in the gold series from Month 3 (halfway through the course of injections) to Month 18 (one year after completion of the course). Thereafter, a reverse trend was noted, so that by Month 30 most of the advantage seen in the gold-treated series at Month 18 had disappeared, though by some criteria the gold-treated series still remained significantly better than the control series, albeit by only a slender margin. Second courses of injections were given to 16 gold-treated patients and 18 controls. The main reason for giving a second course was failure to respond satisfactorily to the first. Analysis of the assessments of these patients confirmed that they formed relatively "bad" groups up to the time of receiving the second course, and that subsequently they did no better. In addition, the 16 who received 2 courses of gold did no better than the 18 who received 2 courses of control injections.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Dextroposition

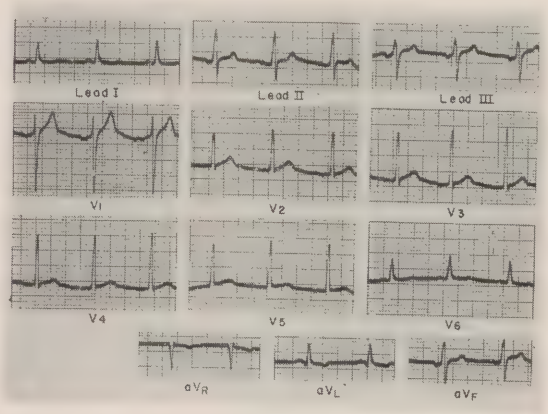
DALE GROOM, M. D.
Department of Medicine

Case Record.—This electrocardiogram was selected because it depicts an unusual position of the heart. Reference to the patient's chest roentgenograms disclosed a dextroposition of the heart due to pulmonary disease. The cardiac shadow and trachea were shifted markedly to the right by contraction and probable atelectasis of the right middle and lower lobes, which were extensively infiltrated with what was considered to be carcinoma with secondary pneumonia, abscess formation and cavitation. It was suggested by the radiologist that the heart had become rotated in a counterclockwise direction as result of the shift of the mediastinum to the right.

The case was that of a 49 year old man who died a few days after admission to the hospital in an advanced stage of debility, presumably due to bronchogenic carcinoma. There was no history or findings indicative of primary cardiac disease.

Electrocardiogram—A right sided position of the heart is suggested principally by the fact that typical left ventricular complexes appear as far to the right as V-2 and progressively decrease in amplitude as one moves the precordial electrode left to the V-6 position. Counterclockwise rotation of the heart (along its axis, as viewed from below) tends to bring the left ventricle around to a more anterior position but were that the only alteration one would expect the electrode at the V-6 position to still record complexes of voltage comparable to that in the mid-precordial area.

P waves in lead I show a normal leftward direction of atrial depolarization although their axis also is shifted as can be seen in other leads. The T wave changes are minimal and non-specific but otherwise this electrocardiogram is unremarkable.



Discussion—There is nothing really diagnostic in this electrocardiogram which is of interest mainly because it demonstrates that the right-sided position of the heart is not a true dextrocardia. The P waves are upright in lead I, the QRS axis is not deviated to the right and the left ventricle faces the left side. The abnormality is that of a shift to the right (with rotation) of a presumably normal heart, often referred to as **dextroposition,** due in this case to pulmonary disease. In this condition the electrocardiogram may be normal, or, if the mediastinum is shifted sufficiently so that the heart lies predominantly on the right side, there may be some decrease in amplitude of the complexes as seen here when the electrode is moved to the conventional positions far to the left.

Differentiated from this is the "mirror image" dextrocardia, a congenital anomaly with complete lateral transposition of the cardiac chambers and, usually, of the abdominal viscera. The clue in dextrocardia is inversion of P waves in lead I which displays the lateral orientation of the heart because it is recorded between the two arms. Another congenital anomaly, dextroversion, occurs without situs inversus and, although the heart lies on the right side the chambers are normally disposed laterally and frequently there are serious associated lesions such as transposition of the great vessels or septal defects.

The pathology of dextroposition is extracardiac and it is acquired rather than congenital.

POISONING OF THE MONTH

Margaret Q. Jenkins, M. D.
Department of Pediatrics

K. L., a 16 month old white female was admitted to the Medical College Hospital on Feb. 22, 1962 because of acute barbiturate intoxication. The child had ingested the barbiturate at about 7:30 the morning of admission when she got up before the parents. After climbing up on the basin in the bathroom and reaching into the medicine cabinet she pulled down the barbiturate capsules, and had ingested 6 Nembutal (pentobarbital) (1½ grain) capsules, by the time she was discovered by the mother. She was taken to the Naval Hospital Emergency Room at about 8:30 a.m. and while gastric lavage was being done, the patient became apneic, requiring laryngeal intubation and respiration with the Bird respirator. She was subsequently transferred to the Medical College Hospital, and was admitted directly to our recovery room where an anesthesiologist saw her in consultation with the pediatrician.

At the time of admission, the patient's color was good. Her respiration was assisted with the Bird respirator. The aeration of the lungs was satisfactory. The heart rate was regular at 120 per minute. The blood pressure was 90/60 mm.Hg. The patient was completely comatose, flaccid, made no response to any type of stimulation and her reflexes were absent.

The patient was receiving at the time of admission an intravenous injection consisting of dextrose in water, and the blood which had been obtained on the patient at the Naval Hospital was sent to the laboratory for barbiturate level which was later reported as 2.8 mg/100 ml.

It was decided to give this patient Emivan by intravenous drip in an attempt to shorten the duration of her barbiturate intoxication, and to maintain her on the Bird respirator with the small iron lung being immediately adjacent in case of need. The patient received the Emivan solution consisting of 100 mg. of Emivan to each 100 ml. of fluid. She received this initially at the rate of 60 ml. per hour. Shortly after admission, while the patient's respiratory tree was being aspirated with the catheter, a small amount of gastric contents was obtained. It was decided to pass the tube into the stomach to be sure that all the gastric contents had been removed. A large amount of yellowish curdled fluid was obtained.

Two hours after admission the patient's respirations had improved sufficiently to discontinue the respirator and she was placed in a Croupette with O_2 water mist.

Four hours after admission the patient responded, moving extremities and to show objection to being moved, etc. The morning after admission, the patient was awake although quite groggy and she had a very loose cough. Twenty-four hours after admission, the patient was transferred to the Pediatric Floor, the Emivan was discontinued, and the patient was offered clear liquids and tetracycline by mouth. Her temperature remained essentially normal througout her hospital course and her blood pressure also remained stable. She had considerable harsh cough, coarse rhonchi, and coarse wheezes following the removal of her endotracheal tube. This required that she be kept in a croupette until the day before discharge, (Feb. 28). The pentobarbital which this patient ingested is one of the short acting barbiturates which, according to Drill[1] produced coma with a blood level of 1-3 mg./100 ml. and death with a level of 2-5 mg./100 ml. (phenobarbital, on the other hand, produces coma at a level of 3-6 mg./100 ml. and death at about 10 mg./100 ml.) This patient's pentobarbital level was 2.8 mg. which is certainly in the dangerous range. The use of the analeptic vanillic acid or ethamivan appeared to shorten the duration of this patient's coma, since within three hours of ingesting the drug and two hours of instituting therapy the patient showed definite evidence of arousing and by five hours after ingestion of the drug was vigorously objecting to being handled.

The recent study by Adriani **et al**[2] showed that the sleeping time of subjects narcotized with barbiturates was definitely reduced with the use of the newer analepics Bemegride, methyphenidate and Ethamivan. He also states that these three drugs are capable of restoration of consciousness and increase in reflex activity in narcotized patients which is not so with picrotoxin, Metrazol or the diethylamides.

REFERENCES

1. Drill, V. A.: Pharmacology In Medicine, a Collaborative Textbook, McGraw-Hill Book Company, Inc. 1958.
2. Adriani, J. Drake P., Arens J.: Use of antagonists in drug-induced coma, J A M A, Mar. 10, 1962.

DERMATOLOGICAL DON'TS

KATHLEEN RILEY, M. D.
Dept. of Dermatology

Case 1 — Tinea Versicolor

White, Male, age 16

HISTORY:

In June after a few weeks of sunbathing, the patient noticed white spots.

They appeared over his shoulders, chest and lower face.

They were completely asymptomatic.

Patient had been told previously that he had vitiligo, an incurable disease.

PHYSICAL EXAMINATION:

Scattered over the upper trunk from the waist to the neck and over the lower face were macular, irregular patches of depigmentation.

A few showed fine, fawn-colored scaling.

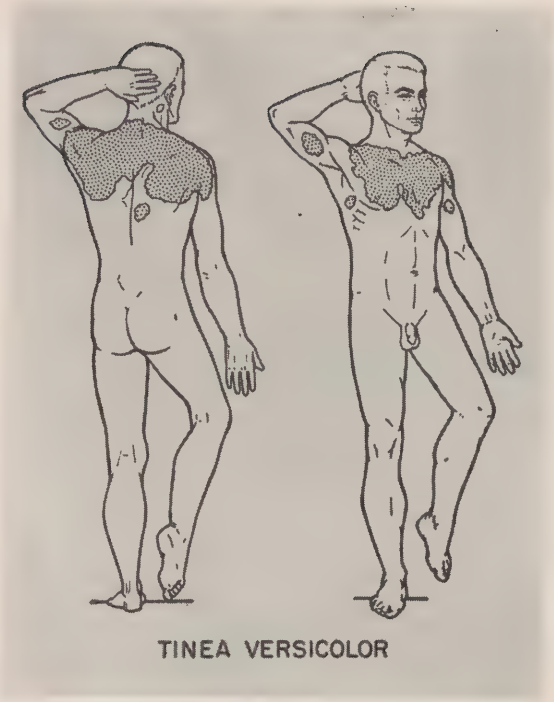
In the dark room these lesions fluoresced under the Wood's light.



A short strip of scotch tape was applied to one depigmented area with gentle pressure and then removed. This tape was then stuck on a clean slide and examined under the microscope. Typical grape-like translucent clusters of microsporin furfur, the causative organism of tinea versicolor were identified under low power.

DIAGNOSIS:
TINEA VERSICOLOR
TREATMENT:
DON'T:

1. Prescribe griseofulvin.



2. Expect white spots to disappear with therapy. They will repigment only after the fungus has been removed and then tanned.

DO:

1. Scrub well all lesions preferably with a brush and a keratolytic soap such as Fostex.
2. After scrubs, a light application of Asterol tincture once each day.
3. Continue this for a minimum of three weeks and checked again with Wood's light or by microscopic examination.
4. As a rule, patients need to follow therapy for four to six weeks.
5. Be sure that clothing which has been worn next to the involved areas has all been laundered.

BUREAUCRACY AT THE BEDSIDE

The matter of naming drugs is presently of top priority. Who is going to name them? Will the Government name them? What system of naming will be employed? Will the doctor prescribe by generic name, brand name, or otherwise? In the same argument, hatched by the Kefauver-Celler Bill, arises the question of who will decide the merits of a given new drug. Will it be the medical profession or a governmantal agency?

—*Nebraska State Medical Journal*, Dec. 1961

President's Page



The South Carolina Medical Association begins its 114th year as the voice of physicians in this state. We feel appreciation for all those who have labored for the betterment of this organization. The Society has worked steadily to improve the public health of our state by better medical care of the patient and by the education of doctors, both as medical students and as practicing physicians. At this time, we who are members of the South Carolina Medical Association can truly say: "We are gathering where we have not sown." We are enjoying the fruits of the labors of others. Let ours be the determination, the effort and the courage to sustain their vision.

In an address delivered before the A. M. A. Institute in Chicago on August 31, 1961, Dr. Leonard W. Larson, President of the American Medical Association, said: "It is my firm belief that the individual physician must be at the core of our medical thought, action and progress. It is his leadership and his assumption of responsibility, initiative and self expression that now must be exerted if the medical profession through the A. M. A. is to be the leader in a new crusade for the best possible health of our people."

The success or failure of the South Carolina Medical Association depends on each of us.

JAMES H. GRESSETTE, M. D.

Editorials

Health Agencies

The recent meeting of the Coordinating Council on Handicapped Children in Columbia gave some promise of development of satisfactory cooperative activities among the numerous voluntary and state health agencies of South Carolina. This Council is a purely voluntary agency composed of representatives of these agencies and has no real authority beyond the weight of opinion which it may develop and express.

In Indiana the State Medical Association has set up a program which would provide machinery for consideration of the merits and operations of the health agencies. The Medical Association has set up certain criteria which an agency must meet in order to gain recognition by the group. These are all reasonable and attainable goals and do not interfere with the activities of the properly organized and properly operated agency. One move is to organize a council which will require submission of an annual report which may be surveyed by the Medical Association.

The matters with which the voluntary agencies deal are matters of health, and they should undoubtedly have strict medical supervision and guidance. The funds which are raised are obtained from the public, which is under the impression that these funds will be properly expended for the goals which have been set. Certainly the physicians deserve an accounting of the medical activities to which many of them contribute time and effort, and the the public deserves an accounting of the way in which its money is to be spent. The reason for organizations such as this one in Indiana is to prevent competition, overlapping, unrealistic goals and promises, and to make the most effective use of the time and money of all the people concerned.

This seems like a reasonable arrangement which South Carolina might want to emulate.

Canadian Compulsion

Just across the northern border of Montana, the Canadian province of Saskatchewan adopted some time ago a compulsory plan for medical care under a socialist government. Physicians of the province protested, calling it "a form of civil conscription," and objected seriously to the government plan to provide fixed fees on a scale to be worked out with a supervising commission rather than with the medical profession. The Health Minister stands firm. So do the doctors; they have refused to have anything to do with the program.

Every resident pays toward the cost of this program to make a total of an estimated $21 milion in its first year. The doctors hold out for an alternative program which would not be compulsory but would supplement insurance services already in existence and add government subsidies to cover expenses for persons unable to pay. The doctors calculate that this would cost roughly one sixth of what the present planned program involves in millions.

The game seems to be at a zero-zero tie. Who will make the first run remains to be seen.

This Wormy World!

"And worms have eaten them,
But not for love."

As You Like It, Act IV, Scene 2

Many years ago intestinal parasites, then largely undifferentiated, were said to be responsible for many serious and even fatal disorders. Children in early South Carolina died of "worm fever" and the

presence of worms was sufficient to explain almost any set of symptoms. Fever, convulsions, lingering illness, eventual death were attributed with reasonable satisfaction to the lowly parasites. Itching of the nose, itching of the anal area, vague abdominal pains and other indefinite symptoms were blamed on the inhabitants of the bowel. Then there came a time in this locality when most worms were regarded with disdain as far as their part in major disease were concerned, except for such more vicious members of the family as the hookworm, who was recognized as a serious disturber of the internal peace.

A relatively recent generation decided that the various symptoms previously attributed to the presence of parasites had little proven connection with worminess.

The tooth grinding, dirt eating, finger sucking child was absolved of the suspicion of worms without laboratory exclusion, and these symptoms were attributed to other sources, even unto the psychiatric.

Now a recent article preaches the gospel that the lowly pin-worm ordinarily considered the least seriously harmful parasite, may be responsible for an immense variety of disorders varying from itching of the anus to dire and drastic diseases such as cerebral lesions, synovitis, asthma, blindness, headaches, bleeding, and a variety which sounds somewhat like the table of contents of a pediatric text. Not only are these many disorders attributed to the pinworm, but their cure is said to be effected by the removal of the offending organism; after treatment even dysrhythmic electroencephalograms may resume their harmless ripples across the paper.

We are somewhat puzzled about this serious respect for the mild pinworm. We have seen instances in which a very large proportion of a group of children, such as those in a large orphanage, showed the presence of pinworms; strangely enough they did not show any but the very mildest of the symptoms attributed to infestation. Could it be that this recently reported batch of sufferers was an abnormal group of children who had a particular fondness for pinworms and a particular tendency for developing strange disorders as well? To prove more convincingly that the pinworm is the responsible agent still seems to be necessary.

This article would not excite our concern had it been left to lie peacably in its pediatric journal, but since it has been picked up and medically popularized in *Medical World News,* it will probably reach a very large number of physicians and create something of a stir. Perhaps it is all true. For ourselves, we prefer to look for other causes of the more violent symptoms listed, rather than to be satisfied with the administration of treatment of pinworms. Pursued to its ultimate logic, this article might suggest the routine administration of the proper vermifuges as a general prophylaxis against the development of disturbing disorders of the young—but things are probably not that simple!

**Archives of Pediatrics,* 78:440

South Carolina Medical Association,
309 W. Evans St.
Florence, S. C., U.S.A.

Gentlemen:

The research library of the Institute of Experimental Medicine and Surgery of the University of Montreal has suffered extensive losses owing to destruction by fire.

In attempting to rebuild our library, we should like to enlist the assistance of the readers of JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION. and ask them to send us all available reprints of their work, especially those dealing with ENDOCRINOLOGY and STRESS.

At the same time we wish to point out that our permanent mailing list was also destroyed, hence we shall be able to send reprints of our own publications only to those of your readers who write for them.

We would be most grateful if you could find some appropriate space in your Journal for the early publication of this request.

Yours sincerely,
Hans Selye, Professor and Director
Institute of Experimental Medicine
and Surgery, University of Montreal
P. O. Box 6128, Montreal 26, Canada

News

Practice Available

An opportunity for a well trained physician to take over a practice plus a fully furnished and equipped office in a college town-rural community has become available due to the death of Dr. S. M. Browne of Clemson. Anyone interested is asked to contact Mrs. S. M. Browne, Clemson, S. C.

Hollings Raps Medical Aid Program

Gov. Ernest F. Hollings rapped the Kennedy administration's newly proposed medical aid to the aged program at a recent meeting of the South Carolina Heart Association. The governor called the newly proposed version of the Forand Bill "a misfit bonanza."

He said it would only aid some 43 per cent of the people in need and not provide for the other 57 per cent.

Gov. Hollings recalled that he was one of 12 governors to vote against the Forand Bill at the National Governor's Conference.

"This new proposal," he said "would give medical aid, but only a type of hospital care." He was also critical that the provisions of the bill haven't been studied and analyzed by the news media and thus reported to the people.

"I feel that we can handle the problem in this state," he said, "and that we can prove we have a heart in our medical profession and in our conservative government."

Bill Would Promote Oldest State Guardsman

An act to promote the oldest living member of the S. C. National Guard to the rank of brigadier general (ret.) has been passed by both houses of the legislature.

Dr. Isadore Schayer, a lieutenant colonel in the National Guard, was retired from active duty in 1944. He had served as chief surgeon of the S. C. National Guard from 1921 until September, 1940.

He enlisted in the S. C. National Guard on May 6, 1898, as a private and served during the Spanish American War, on the Mexican Border in 1916 and in World Wars I and II.

He received the degree of doctor of medicine from the University of Cincinnati in 1902.

Edisto Medical Society

What the medical profession is doing for the elderly citizens of South Carolina and why members of the South Carolina Medical Association are opposed to the King-Anderson Bill and any other socialistic schemes to control medicine was the subject of a meeting of the Edisto Medical Society held March 28. The panel program featured Dr. Charles Wyatt, Dr. J. H. Gressette, Mr. Robert Tomlin and Mr. Jack Meadors.

MeLeod Infirmary Honors Founder

The McLeod Infirmary honored the memory of its founder, Dr. Frank H. McLeod, at a banquet held March 15. At this banquet the first annual Frank H. McLeod Memorial Lecture, which supplants the annual Memorial Seminar, was presented by Major General Robert L. Bohannon, Deputy Surgeon General, U. S. Air Force.

New Doctor for Central

After a period of more than two years without a practicing physician, Central has acquired the services of a medical doctor. Dr. Sam C. Burnett, Jr., of Anderson, began practice on February 12, with offices next door to the Central Pharmacy.

Florence Physician Named To VA Appeal Position

Dr. L. M. Lide who practiced medicine for 32 years in Florence has been appointed medical officer and consultant to the Board of Veterans Appeal of the Veterans Administration in Washington.

His promotion to this position moves him from the Arizona office of the Veterans Administration where he has served for the past seven and one-half years as medical rating specialist.

His new appointment is to the Veterans Administration board with supreme adjudication authority for veterans' disability claims for the entire United States.

S. C. Heart Assn. Names Columbia Man As President

Dr. C. Warren Irvin, Jr., of Columbia succeeded Albert R. Simonds of Charleston as president of the South Carolina Heart Assn. at the 13th Scientific Session and Annual Meeting of the Association.

Mr. Simonds was elected chairman of the board of directors. Also elected to office were Dr. R. P. Walton, Charleston, vice president; Henry M. Lee, Greenville, secretary; and John G. Martin, Columbia, treasurer.

Dr. James V. Warren, president-elect of the American Heart Assn., spoke at the annual Dutch awards luncheon and business meeting at noon today.

During the luncheon the Distinguished Achievement Medallion was presented to Miss Sallie Carrington of Charleston.

A special award, made for the first time, of an honorary life membership on the board of directors of the S. C. Heart Assn., went to Dr. George R. Wilkinson of Greenville.

Mr. Simonds presided at the awards luncheon and business meeting.

Osteopath Bill Rapped By Medicos

Medical doctors and doctors of osteopathy discussed the standards and qualifications of their respective professions in a hearing before the Senate Medical Affairs Committee February 21. The medical men maintained osteopaths should stick to manipulation unless they want to qualify as medicoes.

The committee, headed by Sen. Rembert Dennis of Berkeley, put off a vote on the bill which spurred the debate.

The bill, sponsored by Sen. H. H. Jessen of Dorchester, sought to write into state law updated standards for practicing osteopathy. Members of the profession claim they must meet the same scientific and academic standards, including hospital internship, as those required by doctors of medicine.

The bill also would have allowed osteopaths to perform major surgery and administer and prescribe drugs. Present law allows them to perform minor surgery, such as lancing a boil, and obstetrics. Osteopaths are barred from prescribing drugs.

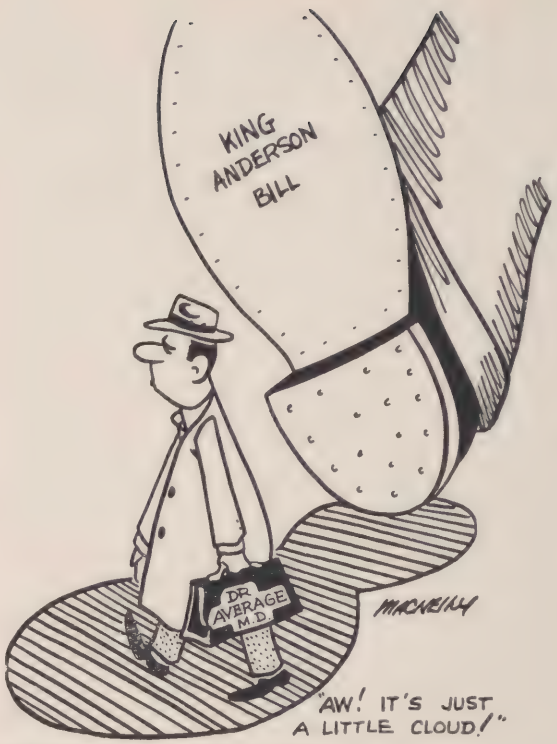
The medical profession was represented by Dr. Charles N. Wyatt of Greenville, president of the South Carolina Medical Association; Dr. J. H. Gressette of Orangeburg, president-elect; Dr. Joseph P. Cain, Jr. of Mullins, state representative to the American Medical Association; Dr. John M. Brewer of Kershaw, chairman of the society's executive council; Dr. Frank C. Owens of Columbia, a member of the Executive Committee of the State Board of Health; and M. L. Meadors of Florence, counsel and executive secretary of the state society.

S. C. Doctors In The News

Among the faces in the news we notice in the "House Physician Reporter" an article which features Dr. Harold E. Jervey, secretary-treasurer of the Federation of State Medical Boards. The Federation is working towards a goal of producing more uniform State Medical Board Examinations and complete reciprocity for licensing among states.

Dr. Jervey reported that a committee had established a pool of obstetrical-gynecological queries as a pilot effort to achieve uniformity in examinations.

In the same publication appears the countenance of Dr. Robert F. Hagerty of Charleston who spoke at Dallas on the prospects of future growth



in developments of plastic surgery. He described the opportunities for plastic surgeons and urged that they be granted increased responsibility during their latter years of training so that they will be better equiped for practice.

Hill-Burton Construction Contract Let

The construction contract for the Hillcrest Hospital Division of Greenville General Hospital at Simpsonville has been let and will provide a new 40-bed air-conditioned facility. The cost is estimated to run around $810,000.

Court Closes S. C. Doctor

A Calhoun Falls physician — Dr. E. P. Elam — has been temporarily restrained from the practice of medicine.

The state attorney general's office made the announcement February 13 after the order was handed down by Judge Steve C. Griffith at Newberry.

Dr. Gould Plans Move Of Offices

Dr. Stanley Gould, whose offices were at 907 Pendleton St., Greenville, moved his location to 6-A Vandry Street Medical Court on March 12.

Pelzer Doctors Are Leaving

Pelzer's only two doctors will leave their general practice June 1 to further their training in specialized fields.

Dr. Sam Pickle and Dr. Max West have been practicing in the Pelzer Hospital since 1958.

Dr. Pickle will take a three-year residency in internal medicine at John Gaston Hospital, Memphis, Tenn. Dr. West will take hospital residency at the State Hospital in Norwich, Conn., to study psychiatry.

Dr. Neil D. Boggess, Jr. of nearby Williamston gave up his practice Feb. 1 and returned to his home in Dalton, Ga.

Applications For Four Hill-Burton Projects Approved

The State Board of Health and the U. S. Public Health Service have approved the initial applications for construction of a new public health center, a hospital addition, a new hospital, and a nursing home.

The public health center is to be located at St. George in Dorchester County. This facility has been estimated to cost $90,000 with a federal share of $60,000 and a local share of $30,000.

The Beaufort Memorial Hospital in Beaufort is to have a 20-bed addition including new surgical and operating suites. It is estimated to cost $750,000 with the federal share at $500,000 and the local share at $250,000.

The new 55-bed Williamsburg County Memorial Hospital at Kinsgtree will replace the present Kelly Memorial Hospital and is estimated to cost $1,100,000. The federal share is estimated at $733,333.33 and the local share at $366,666.67.

The Loris Community Hospital Nursing Home in Loris will be a 35-bed facility and is estimated to cost $225,000 with a federal share of $150,000 and the local share of $75,000.

The American Medical Women's Association

The American Medical Women's Association extends an invitation to all women physicians attending the AMA Annual Meeting in Chicago, to be their guests at a brunch on Sunday, June 24, 1962 at 11:00 A.M. at the Essex Inn.

Those wishing to attend write: American Medical Women's Association, 1790 Broadway, New York 19, N. Y.

S. C. Public Health Association

The South Carolina Public Health Association extends a cordial invitation to all interested persons to become a new member or renew membership in the Association. The annual meeting will be held at the Ocean Forest Hotel, Myrtle Beach, June 7-9, 1962.

The Association, founded in 1921, is the affiliate of the American Public Health Association in South Carolina. Its purpose is to promote actively the objectives of sound public health practice, and assist all those who are responsible for and interested in good public health work.

One of the major activities of the Association is the annual meeting of the entire membership.

Membership in the South Carolina Public Health Association, 426 Wade Hampton State Office Building, Columbia, S. C., is open to individuals in South Carolina who have a strong interest in public health practices. The membership fee is $1.00, due and payable on or before May 1st.

Tri-State Medical Association

The Annual Meeting of the Tri-State Medical Association will be held at the Carolinian Hotel, Nags Head, N. C., from June 10 to June 13. Wives and children will be included in the program and the Carolinian has a children's activity program designed to take care of the children, allowing parents some leisure time.

National Survey of Prothrombin

The College of American Pathologists will conduct a national survey to stimulate interest in the accuracy and precision of prothrombin measurements. Those who wish to participate in the prothrombin survey may do so by applying to the Committee for Clinical Pathology Standards of the College of American Pathologists, Prudential Plaza, Chicago 1, Ill. In addition to the survey samples, a critique on prothrombin measurements containing suggestions for increasing the reproducibility and accuracy will be sent to each participant.

Eli Lilly Seminars Available To Local Medical Groups

Eli Lilly and Company in cooperation with the Commission on Education, American Academy of General Practice, has offered funds to the South Carolina Chapter, American Academy of General Practice, for at least two "decentralized" Seminars in South Carolina during 1962.

The purpose of the Seminar programs is to provide educational opportunities for physicians in areas of the state relatively distant from the Medical Center where advanced study courses might not be readily available. Programs can be arranged on almost any medical subject desired by a group.

Medical Societies or other local groups who might desire a Seminar program to be conducted in their area are requested to contact one of the following:

Dr. Dale Groom, Medical College of S. C.

Dr. J. A. White, Easley, South Carolina

Since the seminars during 1961 were all in the upstate area (by request of the various societies concerned), it is considered especially appropriate to hold one or more of the seminars this year in the lower part of the state. Suggested as

suitable locations are Conway, Florence, Sumter, Aiken, but any area may apply.

J. A. White, M. D., Chairman,
Commission on Education
S. C. Chapter, AAGP

Dr. Chapman Moves Offices

William S. Chapman, M. D., announces the removal of his office to 5105 North King's Highway, Myrtle Beach, S. C.

Southern Medical Association

The Southern Medical Association will hold its Annual Meeting November 12-15, 1962 at the Fontainebleau Hotel, Miami Beach. Exhibits of high caliber are solicited for the Scientific Section. Applications may be obtained from the chairman of the Scientific Exhibit Committee, George F. Schmitt, M. D., 30 S. E. 8th Street, Miami, Florida.

New Film On Syphilis For Medical Societies

The Venereal Disease Control Section has received on indefinite loan from the Public Health Service a 16-mm. motion picture film entitled "The Identification of Early Syphilis,"

This film, lasting 22 minutes in sound and color, deals with signs, symptoms, laboratory tests, and epidemiology of early syphilis. It is designed primarly for the medical profession.

Arrangements for having this film shown to local medical societies should be made by writing directly to Dr. R. W. Ball, Chief, Venereal Disease Control Section. Dr. Ball or a staff representative will be glad to personally bring and present this film to local medical societies.

Clinical Center Study of Glycogen Storage Diseases

The cooperation of physicians is requested in obtaining patients with glycogen storage diseases for a study currently in progress at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Patients with deficient glucose-6-phosphatase are especially needed, but patients with the other types are also being studied. Preferably the diagnosis should be established as a result of enzymatic assays on liver biopsy tissue, but patients who fit the clinical criteria for glycogen storage disease would be considered also.

Hospitalization for a period of one to three weeks should be anticipated and various therapeutic measures would be evaluated.

Physicians who wish to have their patients considered for study should write or telephone: James B. Field, M. D., National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda 14, Maryland.

In Recognition of Dr. Dibble

The Star would not attempt to write a tribute to Dr. E. Marvin Dibble who departed this life recently.

This is more in recognition.

Dr. Dibble's tribute was written each day of the 59 years he lived among the people of the Marion area as a citizen, churchman and physician. The life of a physician, by nature, is intimate. But his mild manner, sincere interest in patients and friends, and unblemished character particularly endeared him to everyone who knew him.

To quite a number of Marionites, who used him professionally throughout their lives, there was no other doctor. He administered to the physical needs of families of four generations and even in his failing years it was "Dr. Dibble" or nobody to many of the elderly of this community.

Truly Dr. Dibble was a physician of the old school. His years of service saw many innovations both in medical and mechanical science. In his early practice he used the luxury of the day — a horse and buggy. At one time he speeded up his service to the sick by means of a motorcycle. And with the advent of the automobile Dr. Dibble became one of the industry's best customers.

Unlike many of the old-time doctors, Dr. Dibble kept abreast with modern medicine. In his early practice he no doubt prescribed castor oil, home-made pink pills and many of the other basic remedies, but as headaches developed to migraines, belly aches to bugs, and yellow jaundice to hepatitis, Dr. Dibble developed with them. It was his pleasure to live to see the day when many dreaded diseases were conquered with the discovery of miracle drugs such as sulfa, penicillin and aureomycin.

And Dr. "D", as he was affectionately known, also spanked his share of new-borns. As far back as 1954 he estimated that he had delivered as many as 1500 babies.

We would also not attempt to list the honors and accomplishments of this beloved citizen who has made his home here since 1903. But it is fitting that in 1956 he was voted Marion's Outstanding Citizen of the Year.

And truly he was an outstanding citizen. That year and every year. Here was a man that will be missed not only by his family but by the many, many who learned to know and love him.

—From *The Marion Star*, Feb. 22, 1962

Public Relations

NOW HEAR THIS!!

CALLING ALL SOUTH CAROLINA DOCTORS...

King-Anderson Protaganists Sharpen Attacks on Medical Profession

March 24—National Democratic Chairman, John M. Bailey, attacks American Medical Association. Chairman Bailey calls AMA "an ally of the John Birch Society in surgical masks".

March 27—President Kennedy meets with a delegation of doctors headed by Dr. C. B. Esselstyn, Judson, N. Y., a non-member of the AMA, and an admitted supporter of socialized governmental health programs.

May 20—President Kennedy is slated to appear at a mass rally in Madison Square Garden . . . a bold attempt to stir up emotional support for the King-Anderson Bill and to ram it through Congress.

South Carolina physicians have taken steps to counteract these moves. On Sunday, March 25, leading physicians answered the Bailey charge. Their comments appeared in the **News & Courier.** These comments were supported by an editorial appearing in the same issue. The editorial said, in part:

> "No evidence of any relationship between the AMA and the John Birch Society was offered by Mr. Bailey. He had none. Mr. Bailey's statement represents a dangerous form of extremism. He would deny doctors the right to free speech. For example, he specifically objected to doctors giving their views to both patients and the general public. This is precisely the danger that critics of socialized medicine have warned against. Here one finds a professional politician saying that doctors may not present their views on medical care."

On reading the announcement of President Kennedy's meeting with Dr. Esselstyn's group, the Association's public relations committee wrote AMA for full information. A statement was received from Dr. Blasingame, executive vice president, A.M.A. This, along with a statement from Dr. J. I. Waring, was sent to the state's newspapers, pointing out that Dr. Esselystyn does not represent a majority of the medical profession, nor are his views in the best interest of American medicine.

ARE YOU fighting back with the available weapons? These weapons are the Association's speakers bureaus; the editorial and news columns of the state's newspapers; and free air time offered by South Carolina radio stations. Check the order blank at the end of this section for the materials you can use in your community.

SUPPORT FROM WASHINGTON

The following letter was directed to Wilbur D. Mills, Chairman, Ways and Means Committee, House of Representatives, from South Carolina Congressman, William Jennings Bryan Dorn:

"Dear Wilbur:

It is my earnest hope that your great Committee on Ways and Means will reject the King Bill. I sincerely believe this Bill would inevitably lead to complete socialized medicine in the United States.

We have the highest medical standards in the world and these standards are constantly being elevated by persistent research and the dedication to medicine of our splendid physicians throughout this nation. England, under socialized medicine, is losing hundreds of its youngest and most highly trained doctors annually; and England's medical care for all classes is suffering the consequences.

My urgent plea to you and to my Colleagues on Ways and Means is to permit the Kerr-Mills Bill, co-authored by yourself, to be given a thorough trial. It will definitely provide medical care for our aged who are financially unable to meet the medical requirements of advancing years. The Kerr-

Mills is a States' Rights Bill expressing confidence in and cooperation with the States and local communities.

Mr. Chairman, to me, it is unthinkable to jeopardize our social security program with the King Bill when the Kerr-Mills Bill will provide medical care for the needy aged without imperiling and bankrupting the entire social security program."

Respectfully and sincerely yours,
Wm. Jennings Bryan Dorn, M. C.



EDITORIAL SUPPORT:

The following editorial appeared in the **Columbia Record,** Friday, March 9. It is typical of the fine support the South Carolina Medical Association is receiving from the state's newspapers.

MEDICAL CARE FOR AGED IN S. C.

"If one listened to hirelings of the Kennedys, he'd suppose that the elderly of the country, universally, were receiving no medical care. Such, of course, is not the truth.

Not only are many of the country's senior citizens paying their own way through medical insurance—which they prefer—but less fortunate others are receiving assistance from the states under the Kerr-Mills Act.

In South Carolina, for example, there were 951 cases cared for in January of this year. Of these, 469 received in-patient care with payments of $116,645.18, an average of $248.71 per case. Outpatient care was given to 482 cases at a total cost of $5,113.50, averaging $10.61 per case.

For in-patient care, Spartanburg County residents received $7,897.40 (averaging $493.59 per case), Richland County elderly $7,095.49 ($337.88 per case) and Colleton County people $6,831.78 (or an average of $243.99 for the 28 cases).

There were 210 cases of out-patient care in Charleston County, 125 in Greenville and only 51 in Richland.

At the end of January, the State Department of Public Welfare had 2,844 cases of medical assistance for the aged under care. And they had 580 cases pending. During January, they approved assistance for 498 cases while 193 were either denied or otherwise terminated.

None of these figures, of course, includes financial assistance to the elderly through old age or general assistance, help for the totally and permanently disabled or disbursement of local funds.

In medical payments by local funds, the counties spent $10,418.42 in January. Some of the persons receiving such help were receiving another type of assistance; others were not.

When South Carolinians consider the wisdom, or lack of wisdom, of the Kennedy's medicare program, they should not succumb quickly to the propaganda of administration officials, but should calculate the facts before reaching a decision."

At the request of the Charleston **News & Courier,** Dr. J. I. Waring prepared an article which appeared in that newspaper on Sunday, March 18. Here are excerpts:

WHY DOCTORS FIGHT U. S. HANDOUT TO AGED

"The Kennedy Administration, organized labor, the American Nursing Association, the American Hospital Association, and a host of elderly persons (who think they will get something for nothing) have been strong supporters of this bill. (King-Anderson). The medical profession sees in it a threat to the integrity of the patient-physician relation, and an obvious threat of more government interference in private affairs, as well as a tremendous cost to the country. Much of the cost will involve benefits to many elderly persons who are in no need of such help."

"There will be no specified interference with the choice of physician, but the doctor's ability to participate in the program will depend on his hospital connections, which vary widely in different areas. A situation might arise in which the only hospital in a fairly large area has no contract with the government and therefore cannot furnish desired services. These services must then be obtained at some distant hospital which is under federal supervision."

"The Bill as written provides that there shall be no means test, implying, and by discussion and comment, indicating that the means test is an intrusion on the privacy of the beneficiary, and a degradation of his status. The physician feels that this is an absurd stand, that means tests are applied every day when a patient goes to a physician, when he asks for credit at any store or applies to a veterans hospital for recognition as an indigent (a much abused activity), when he makes out an income tax, and in many other ways."

"As a preferable and apparently satisfactory arrangement, the medical profession approves the Kerr-Mills Act which has already been implemented in a great many states, including South Carolina, and is functioning very satisfactorily in all."

"The Chief differences in the two programs are:

1. The Kerr-Mills Act provides for help only to those who need it. The King-Anderson provides help for everyone under Social Security regardless of need. It does not provide for those numerous people who are not on Social Security.

2. The Kerr-Mills Act is subject to considerable latitude in regulation by individual states. The King-Anderson Bill makes no such provision.

3. The Kerr-Mills Act is a going operation. It appears to be serving the demonstrated need and the intended purpose and should have every opportunity for a thorough trial."

"In a financial way, it is unlikely that the physician would suffer from the changes brought about by the King-Anderson proposal. In fact, he might even be better off. However, his sincere conviction is that this bill will not accomplish the desired ends, and that it is an undesirable, unfair threat to relations with the public and to the pocketbook of the taxpayer, already drained to the point of desiccation."

The foregoing articles are typical of the support you can gain from your local newspaper. Put the facts before the editors in your community.



NEW RADIO TAPES:

The second in a series of radio tapes, featuring comments by South Carolina's medical and legislative leaders, is now available. This tape contains statements from Senator Strom Thurmond. These statements are strong arguments against the King-Anderson Bill. See that this and earlier recordings are made available to your local radio stations.



SPEAKERS BUREAUS:

In addition to the prepared speeches listed on the order blank the Association has received an address by Senator Strom Thurmond, delivered on the Senate Floor, stating a clear and forceful case against the King-Anderson Bill. Senator Thurmond has been most cooperative in granting permission to quote at will from this address. If you are planning to speak on this subject in your community, this address will furnish excellent ammunition.

ORDER BLANK

S. C. Medical Association

Public Relations Committee

P. O. Box 275, Charleston, S. C.

Please send the following:

RADIO RECORDINGS

#1 #3 #5
#2 #4 #6

SPEAKERS BUREAU KITS (Quantity)

BASIC NEWS RELEASE (Quantity)

SPEECHES

#1 #5
#2 #6
#3 #7
#4 #8

PAMPHLETS (Quantity)

☐ Cost of Medical Care (1940-1960)
☐ Socialized Medicine & You
☐ Health Care for the Aged
☐ It's Your Decision (Help those who need help)
☐ A Family Doctor's Fight (Reprint, **Look Magazine**)

NAME_____

ADDRESS_____

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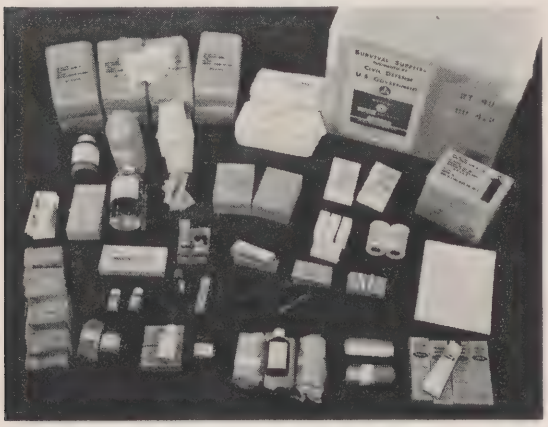
Key to Speeches

#1 King-Anderson
#2 Food Faddism
#3 Hospital Costs
#4 Hidden Hazards (Household Poisons)
#5 Care & Preservation American Businessman
#6 Mental Health
#7 Medicine as a Career
#8 7 Ways to Cut Medical Expenses

Key to Radio Tapes

#1 King-Anderson (Dr. Wyatt)
#2 King-Anderson (Quotations Bryan Dorn)
#3 King-Anderson
#4 Quackery
#5 King-Anderson (Dr. Gressette)
#6 King-Anderson (quotations Strom Thurmond)

Civil Defense



The survival kit—designed for storage in public fallout shelters—includes medicines, dressings and other vital medical supplies needed to treat a wide range of injuries or diseases. The kits are now being mass-produced and will be stockpiled in approved public shelters throughout South Carolina.

CIVIL DEFENSE

Emergency medical kits devised for stockpiling in public fallout shelters are now undergoing inspection by officials of the State Health Department and the South Carolina Civil Defense Agency.

Containing the basic medical supplies chosen by experts in disaster medicine of the Public Health Service and the American Medical Association, the kits are designed to answer the problems of emergency medical care which are bound to arise during periods of restricted confinement in a pubilc fallout shelter.

The National Fallout Shelter Survey, now in progress in all the 50 states, is predicted to reveal shelter space in existing structures which could house some 50 million Americans. In South Carolina the initial phase of the survey, completed in 42 of the state's 46 counties, has turned up 1,314 buildings capable of providing a protection factor of 20 against the dangers of radioactive fallout.

However, all of the more than 1300 facilities must now undergo further intensive inspection of structural components to determine if the buildings will provide a protection factor of 100. (This means that only one per cent of the outside radiation would penetrate the building). In addition to the protection factor, each shelter must contain sufficient space to house a minimum of 50 persons and space for stockpiling of essential supplies.

Components of the medical kits vary in quantity to accommodate 50, 100 or 300 persons. For example, a shelter accommodating 1,000 would have stored in the shelter area at least three of the larger kits. In addition to medical supplies, there will be stockpiled sanitary supplies, food, water and radiological monitoring instruments.

Short Courses

The Army Medical Service has announced that it has completed arrangements for postgraduate professional short courses on "Management of Mass Casualties" as follows:

Medical Field Service School, October 8-12, 1962; Brooke Army Medical Center, Fort Sam Houston, Texas, March 25-29, 1963; Walter Reed Army Institute of Research, Washington 12, D. C., October 30-November 1, 1962.

Under the quota allotted to the AMA Department of National Security, spaces are open for ten civilian physicians to attend each of the above courses. Those desiring to attend one of the courses should write to the AMA Department of National Security, 535 N. Dearborn St., Chicago 10, Illinois.

COMPETITION HAS REDUCED DRUG COSTS

Competition explains why antibiotics now cost about one-fifth of what they cost a decade ago, on the average. It explains why penicillin prices are now 5% of what they were after World War II. It explains why insulin costs 6% of what it cost 30 years ago; why streptomycin prices dropped 40% in less than a year; why Salk vaccine prices have been cut in half. Chemotherapy has helped bring good health to three million Americans who wouldn't be alive today if pre-war rates still applied.—Edward R. Annis, M. D., in "Medical Economics," July 17, 1961.

PRICES AND POLITICAL PROMISES

For the first time, medical care and drugs have become recognized items of cost that the public is not used to—and they don't like it. It makes little difference that the cost is still cheap and within the means of most people. They still don't like it, especially when some of our politicians tell them that the costs are too high—and through legislation "I can get it for you for free or for practically nothing." —Theodore G. Klumpp, M. D., President, Winthrop Laboratories, in "New York Medicine," Aug. 20, 1961.

Status in Medicine

(All for Boards and Boards for All)

BERNARD E. FERRARA
CHARLESTON, S.C.

Status in social and business life has been emphasized by Vance Packard's book *The Status Seekers.* Whether or not ours is agreement or rancor at the designation, status is important.

Since much interest (and despair) has been generated by our president and the course of government since his election; and since his origin is Irish-American, I was much interested in a book review by one of similar origin, J. Gregory Dunne. Mr. Dunne commented on Edwin O'Connor's apologia of the Irish-American—*The Edge of Sadness.*

Mr. Dunne was grieved by the importance of status in the Northeast Irish-American and the shattering effect on his group, which effect he had noted in his own way of life. The conviction was expressed in the book and further emphasized by Mr. Dunne that as affluence accrued, and as influence was gained, confluence resulted. Mr. Dunne regretted that basic qualities of loyalty, determination and dedication were lost in the amalgam.

These introductory remarks serve only to emphasize, that status seeking is characteristic of ethnic groups, as well as individuals. All of us as doctors are status seekers of sorts. Our very position in the community as doctor indicates status. It is only natural that we should want to improve our status.

I must digress a bit and discuss briefly the organization men of medicine. These are gentlemen of towering professional status. They are politicians of varying degrees. Very few of them have status forced upon them. It has been gained, only after it was sought, fought for, and perhaps at times stolen from others. In medicine it is the organization man who collects status symbols and forces us, his political constituents, (we never oppose designates of nominating committees) to elevate him to a position of importance, whence his monumental incompetence, at long last, becomes apparent.

The organization man of medicine is also an image maker. (A disgusting term, but so commonly used, everyone understands.) He berates other doctors for presenting the deplorable side of medicine—personal riches—to the public. He says we have to be self-effacing—no publicity—(he has learned which profile is best for rotagravure shots). He castigates us for disharmony. (We have not yet acquired his pitch nor his tune.) We cheat insurance companies. (He owns a part of several.) We don't do charity work. (As director, he is paid for his time.) And so on ad infinitum, ad nauseam. After such public decimation of our character and morale, the humble, benevolent image maker retires from the podium, ignites a 75¢ cigar, brushes the ash from his $300 suit, and powers his Cadillac homeward.

To return to the subject—status as it affects us, there have been two recent developments in medicine, which have been seized upon by the status seekers, as a raison d'etre. Two new boards of medical examiners will soon be appointed and seem assured—a board of abdominal surgery and a board of general practice.

My sentiments regarding the board of abdominal surgery are expressed in the following excerpts from my letter of June 26, 1960, to Dr. Blaise F. Alfono, secretary of the group. "Thank you very much for your letter of June 19, 1960, regarding the founders group of the American Board of Abdominal Surgery. I am completely out of sympathy with the establishment of such a board. On speaking with more responsible members of the surgical profession there seems to be no need for such a group. The retreat into the abdomen of one trained in the broad field of general surgery is an admission of incompetence. . . . The idea of establishing a board for hysterectomy and gall bladder surgeons is obnoxious to me.

"In these troubled times it should be obvious to the sensitive individual that the world abounds with jackasses. It is disturbing to me to learn that there are 4600 jackasses amongst us who call ourselves surgeons. That these 4600 individuals should constitute your founders group seems quite appropriate.

"It is hardly worthwhile to wish you ill in your absurd venture. Yours very truly - - -".

I was wrong, of course. It was not an absurd venture. The surgical section of the American Medical Association on June 27, 1961 agreed to sponsor such a group. O tempora! O mores!

A board of general practice seems in the offing. A group of organizational physicians have been organizing it for several years. The American Academy of General Practice has recently approved such action after having first rejected it. But, the status seeking organization men have overpowered the opposition. Predictably, it will be within three to five years that such a board will be approved and established by the American Medical Association.

One ridiculous aspect of both such ventures—that is, establishment of the two boards alluded to, is the rush of incompetents to become members of the founders group. Perhaps, there are visions of adding gold chevrons or a purple mantle to the academic gown—or, maybe, even, an ermine stole. It does give the prerogative of absolution from tests of competence, while administering such to succeeding candidates.

Is there no room in medicine any more for just a plain doctor? Apparently not! He needs more status! And, status will be forced upon him.

The organization men seem determined to improve our image to the public. Such action as establishment of unnecessary boards is without merit. Certainly the number of boards already existing is staggering; and many are not necessary.

Specialization should be a determined effort on the part of an individual to improve and gain competence in a field of endeavor which is not intellectually limited. After all, ills of the body and mind and various organ systems are interrelated—and failure to

recall this accounts for some of the drastic errors we perpetrate. A limitation of knowledge is not desirable, although overspecialization is such an escape from the necessity of learning. The old aphorism about specialization has the ring of truth. To wit, the specialist being a man who learns more and more about less and less until he reaches a point where he knows everything about nothing.

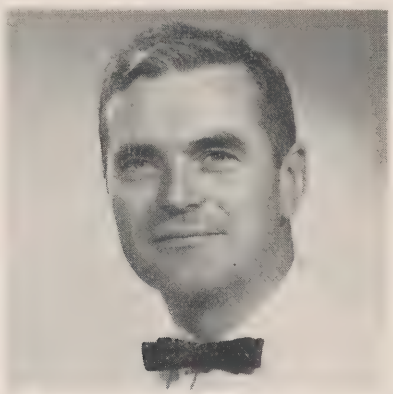
The acceptance of each of these boards by South Carolina doctors should be gratifying to the founding groups. Before the stampede for universal medical board designation becomes uncontrollable, I think that all of us should ponder the motives of such founding groups, the necessity of their existence, and the personal and public advantages of each. I firmly believe that qualified in such context, these proposed new boards are a waste of energy, intelligence, and wisdom. They are status symbols, to be offered and sought for by individuals who can be categorized as organization men.

It is further encumbent upon each of us to respect and protect our dignity as physicians, and not to be deceived by the ambitions of insincere medical politicians. It is further necessary that we critically assess the medical leadership in local and state associations, and in the American Medical Association. Such board groups do not begin as grass roots movements. They begin with the organization men already given positions of power by us, by our failure to examine critically their competence to administer and execute such offices as they are elected to.

I state without reservation, that the only reason for establishment of such boards is the desire of certain ambitious men to gain status or improve upon what is theirs.

Mr. William Ball, former Editor of the *News and Courier*, frequently wrote, when despairing of national political hijinks, "There are no boobs in South Carolina."

Are there?



Surgery Chief Named At Medical College

Dr. George H. A. Clowes, Jr. of Cleveland Metropolitan General Hospital has been named professor and chairman of the department of surgery at the Medical College of South Carolina.

The surgeon, who has been serving as surgeon-in-charge of thoracic surgical service at the Cleveland hospital, and his family will arrive in July.

Dr. Clowes received his BS from Harvard College in 1937 and his MD degree from the Harvard Medical School in 1941.

While at the University of Toronto as a fellow in surgery, the doctor received his MA degree in physiology. After doing research work at the Canadian school, Dr. Clowes joined the faculty of Western Reserve University in 1951. In 1958 he was named associate professor of surgery at the Cleveland school.

He became a diplomate of the American Board of Surgery in 1950.

He has developed a membrane blood oxygenator and a number of techniques for open heart surgery.

Dr. Clowes has made 38 contributions to scientific literature.

Many Medical Societies Act Fast To Launch New Public Service Ads

Medical societies around the country are setting the wheels in motion for a new public service advertising campaign designed to reach the public with medicine's story and improve medical press relations.

The first six in this new series of open-end ads for placement in local newspapers were sent by the American Medical Association to county societies January 29. An advance mailing was sent to state societies earlier in the month.

Ads deal with choosing a doctor, medical society grievance committees, the doctor-patient relationship, immunization, medicine's traditional guarantee of care for all, and cost of medical care. They are simple, straight-forward and non-political.

In the first two weeks of February preliminary reports indicated growing interest and acceptance of the campaign, prepared by the American Medical Association for its state and county societies on the recommendation of its Communications Advisory Committee. The committee is composed of executive secretaries representing state and county societies.

Two western states were the first to report full-scale efforts to implement the campaign. Working closely with the Colorado Press Association the Colorado Medical Society is completing a plan to place ads in 118 Colorado daily and weekly newspapers. The society is rewriting AMA ads to fit the local situation and is preparing additional ones in the same style for a series scheduled to begin in mid-February and run till mid-June. Ads will be signed by the county medical society in the area in which they appear if its members give permission, or by the state medical society.

Additional paragraphs offering society speakers and literature on ad topics or related subjects also will be carried.

The American Medical Association said that President Kennedy misstated the real issue when he renewed his request to Congress for legislation that would provide limited health care for the aged under social security.

"We believe the American people are entitled to know that the real issue is not medical care versus no medical care for the elderly." Dr. Leonard W. Larson, president of the A. M. A. said.

"The real issue is: should wage-earners and employers be forced to pay a substantial increase in taxes to provide medical care for millions financially able to take care of themselves?

"No one supporting this proposal has yet presented any evidence that such radical legislation is needed.

"The medical profession is for the Kerr-Mills law to help the aged who need help. We are for voluntary enterprise, including health insurance and prepayment plans for the non-needy aged."

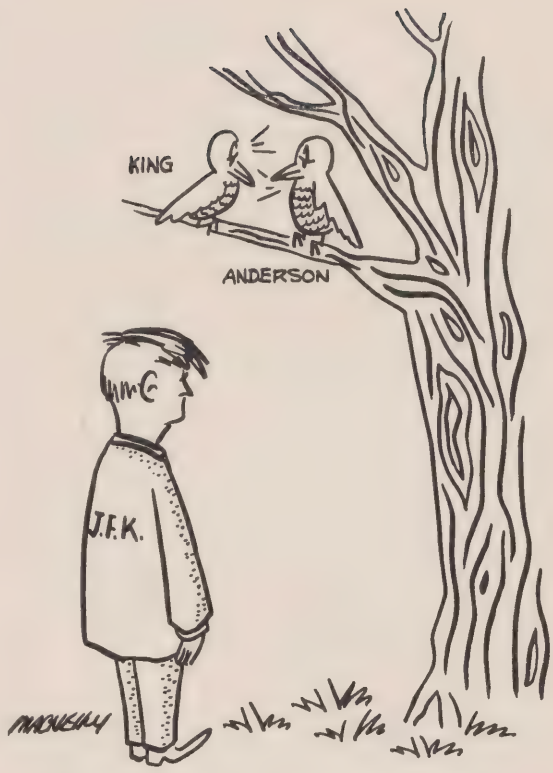
Dr. Larson also disputed other statements on the issue which President Kennedy made in a new health message to Congress. Dr. Larson said that contrary to what Mr. Kennedy said, the Administration legislation (the King-Anderson bill) could interfere with the patient's freedom of choice of hospital and physician.

It would give the federal government "such broad power to control the practice of medicine in the nation's hospitals that the Secretary of Health, Education and Welfare would literally become the czar of American medicine," Dr. Larson said.

Dr. Larson also pointed out that it would not be a health insurance program as President Kennedy said. Instead, it was "political medicine," Dr. Larson said.

"As the Supreme Court of the United States has ruled, Social Security is strictly a tax program with current taxes used principally to provide benefits for those now retired," Dr. Larson said.

AMA The Month in Washington



"IN THE SPRING A YOUNG MAN'S FANCY...."

Dr. Heavrin Has Post In Alaska

Dr. Lawrence Heavrin has reported for duty at the new 50-bed Alaska Native Hospital in Kotzebue, according to Dr. K. Kasuga, medical officer in charge of the U. S. Public Health Service's Alaska Native Health Area Office.

Dr. Heavrin attended Illinois Normal University and the University of South Carolina. He is a 1960 graduate of the Medical College of South Carolina and recently completed his internship at Greenville General Hospital, Greenville, S. C.

Vascular headache. C. D. Aring. Arch Intern Med —Vol. 109:18 (Jan.) 1962.

A variety of untoward factors may result in migraine attack—personality problems, altered vasomotor tone, and the local production of a noxious agent(s) capable of increasing lapillary permeability and lowering pain threshold. The therapy that is most often neglected is the conscientious elicitation of history and the performance of a thoroughgoing physical examination, followed by an explanation to the patient in nonmedical terms. Perhaps re-education is the most useful factor in symptom relief. Ergotamine tartrate (by mouth, sublingually, by inhalation, or by rectum) is a helpful adjunct; sedative and "tranquilizing" drugs have limited usefulness. UML-491 (1-methyl-D-lyseric acid butanolamide bimaleate) may be of prophylactic use; rarely it has been associated with the production of occlusive vascular disorder.

The cardiovascular effects of halothane. John E. Mahaffey, M. D., Earl E. Aldinger, Ph. D., James H. Sprouse, M. D., Thomas D. Darby, Ph. D., and Wendell B. Thrower, M. D. (Charleston) Anesthesiology 22:982.

The occurrence of hypotension during halothane (Fluothane) anesthesia has been frequently emphasized as a primary limiting factor in the usefulness of this agent. This study was conducted in 18 dogs and 10 patients. The parameters investigated were ventricular contractile force, cardiac output, and blood pressure. Contractile force, blood pressure and cardiac output were depressed in a parallel degree with increasing depth of anesthesia. This was noted to be significant when the concentration of halothane in the inspired air was 1.2%. The reduction in cardiac output and blood pressure is attributed primarily to the direct depressant effect of halothane on the myocardium.

FIRES AND SPRING CLEANING

There are about 800 home fires a day in the United States, and too many of these feed on accumulations of rubbish in the attic or the basement.

Begin your Spring Clean-Up job by taking a look around the attic. Do you need that stack of old magazines? Do you have to keep that pile of old newspapers? Will you ever fix the rocker on that old chair and use it again? Why are you keeping that mattress for the bed you disposed of three years ago? And how about that stack of old clothes which has been gathering dust for 10 years?

Give the basement the same going over. If yours is the average home, you will probably find partly filled paint cans, old paint brushes, rags and other combustibles. Throw them out if you have no further use for them. See to it that any paint you retain is kept in tightly sealed metal containers, and be sure paint and other flammables are not stored too close to the heating plant.

And make a note on your calendar now to have the serviceman check your heating plant sometime this summer. It's a good thing to have it serviced every year. At least one fire out of every 10 begins in a defective heating unit.

If you have a washing machine, call a repairman at once if the motor is not functioning properly.

If you have a clothes dryer, see to it that the vent, heating unit and the lint catcher are free of lint. Accumulation of lint anywhere in the dryer is an invitation for a fire.

Never put anything made of foam rubber in your dryer. This includes such items as small pillows, toys, ironing board pads, and Junior's football shoulder pads. Foam rubber can ignite spontaneously at the temperatures attained in a dryer.

Now check your kitchen for fire hazards. If there are loose connections on any electrical appliances, such as the toaster, mixer, refrigerator or electric boiler, have them repaired immediately by a competent electrician.

Take a look around the kitchen to see if there are obvious fire hazards. Most every kitchen has a towel rack. Be sure yours is not in a position where towels hang over the top of the stove.

In the living room potential fire hazards are faulty wiring on lamps, the radio or the television set. The next time you have the electrician in, have him check wiring and electrical connections throughout the house.

And be sure your television set is in a place where there is adequate ventilation. A set naturally generates a considerable amount of heat, and if not properly ventilated, it could cause a fire.

When your fireplace is in use, it should always be protected by a metal screen. Sparks can pop out from a burning log at any time.

If there are smokers in your house, place plenty of ash trays in every room.

The garage is another place where fire hazards frequently build up. Keep the floor of the garage free from oil which may drip from your car. If you have a power lawnmower or outboard motor, keep gasoline in a can approved by Underwriters' Laboratories, Inc. And rememer, keep gasoline only in the garage, never in the house.

If you use turpentine for the mixing of paints, keep it in a tight metal container. If you have it in a bottle and the bottle drops to the floor and breaks, you have flooded the floor with a flammable fluid.

If you are a do-it-yourself-handyman around the house, use care with paints at all times, as well as during your Spring cleaning.

Keep a window open while painting interior walls.

Only a few months ago two men were painting the floor of a living room in a private house when an extension cord with a light bulb dropped to the floor. The bulb broke, the hot filament ignited the wet paint, and damage to the house from the fire was $14,000.

Your clean-up job will not be complete until you have raked up your yard. Most communities do not permit open fires; some require a householder desiring to burn leaves or trash to get a permit to do so. If you do burn leaves or rubbish, however, burn them in a wire mesh basket of the incinerator type—one with a mesh cover which fits securely in place. Have the garden hose hooked up to an outside faucet for use if the fire should get out of hand. And never, never burn on a windy day.

You should get a double pleasure out of your Spring Clean-Up job when it is complete. You will not only have a spic and span home but you will have eliminated potential fire hazards.

NOTICE

Due to the death of Dr. S. M. Browne, of Clemson, S. C., there exists an opening for a well trained physician to take over his practice. Anyone interested in either renting his office, fully furnished and equipped, or in buying any or all of his office equipment, please contact Mrs. S. M. Browne, Clemson, S. C.

Book Reviews

CLINICAL OBSTETRICS, by Benjamin Tenney, M. D. and Bryan Little, M. D. 424 pages. W. B. Saunders Company, Philadelphia, 1961—$8.50.

The teaching experience of the authors of this book is suggestive of its interest to practitioners and students of obstetrics. They are both on the faculty of Harvard Medical School. One is the Director, and the other is Associate Director of the Department of Obstetrics and Gynecology of the Boston City Hospital.

The book is not a compendium, nor is it encyclopedic. The authors in the preface state their objective and intent and indicate the book's scope. They say:

"We were motivated primarily by the desire to express clearly and simply the clinical approach to the major problems that are encountered in private practice . . . (and) only those advances that have demonstrated clinical value are considered."

They continue:

"A basic philosophy and simple and orderly presentation of the material" is essential in undergraduate teaching. They state that this should be combined with a "grouping and careful study of pathological entities for the purpose of ascertaining the best method of treatment . . . In a training program, it is important to teach one good method and have it clearly understood."

The book is dedicated to the residents and nurses of the Department of Obstetrics and Gynecology, Boston City Hospital.

The objectives and the attitudes of the authors toward undergraduate teaching, and the dedication of the book to residents, interns, and nurses should not mislead one.

The book is quite mature and adult. It is written in an interesting style, and is quite readable. Other teachers and experts in obstetrics will find it interesting in that it is an exposé of the ideas, attitudes, and clinical approach used by the authors. Those who are less well trained and not so experienced will find it a highly satisfactory guide.

There are 24 chapters, each devoted to a specific or to closely related problems. They deal with prenatal care, the medical complications of pregnancy, pathological morphologic complications, abnormal bleedings, infections, problems of abortions and of ectopic pregnancy, anesthesia and analgesia, and postpartum care. There is a good discussion of cesarean section, a chapter on abnormal presentations, one on prolonged labor and one on prematurity.

The chapter on diabetes in pregnancy is particularly valuable. The authors have been influenced by the attitude and experience of Dr. Priscilla White and the Joslin Diabetic Clinic.

The chapter on anesthesia and analgesia does not comply with the objectives stated in the preface. It gives the reader an impression of confusion and indecision on the part of the authors and leaves him equally confused.

However, the chapter on blood incompatabilities (especially Rh factor incompatabilities) is excellent and clear cut. Tubal pregnancy is presented quite well, and so is bleeding in the third trimester. The dangers of third stage of labor and how they may be handled are well presented.

There is some tendency to be repetitious. While iteration and reiteration is a valuable and, perhaps, necessary teaching technique, it becomes a little boring when one reads in continuity. The reviewer did read this book in continuity because he found it interesting and helpful. He believes that other readers will have a similar experience. Because of the conciseness (in the main) of the programs discussed, the book will serve also as one for ready reference, when one is confronted with an obstetrical problem.

J. Decherd Guess, M. D.

THE DOCTOR BUSINESS, by Richard Carter. Revised edition. Dolphin Books, Doubleday & Co., Inc. Garden City, N. Y. $.95.

This is a book by an author who has many grievances against the medical profession, and does not hesitate to expound them in terms of unveiled antagonism. It has many of the old charges against the profession and nothing to offer in the way of improvement.

When this book was published a few years ago, it received some rather scathing comment from the medical reviewers. There seems to be little reason why the medical attitude should change. For those medical readers who like to enjoy the physiologic stimulus of indignation, it might be readable. For those nonmedical readers who wish to gather material for further attacks on the profession, it might be a useful handbook.

J. I. W.

COMPARATIVE EPIDEMIOLOGY OF THE MENTAL DISORDERS. Edited by Paul H. Hoch, M. D., and Joseph Zubin, Ph. D. Grune & Stratton 1961. 273 pages. $9.75.

This book is an intensive demographic study of mental illness from the point of view of determining not only disease rates, but the effectiveness of treatment procedures. For the past 20 years there has been an increasing interest in applying epidemiological methods of research to the vast problem of mental illness.

In this particular book, there are research studies in schizophrenia and other mental disorders from many parts of the world, notably the United States, Scandinavia, Great Britain and a special research

study conducted in the particular county of Nova Scotia.

The essence of the book is most interesting from two points of view; first, it attempts to demonstrate that with the improvement in controlling the illness through the wide use of pharmacological therapy the more underlying features of the illness can be more clearly perceived, that is that the treatment of mental illness is coming to the point where, on a larger scale, psychiatry as a whole is coming more to grips with the basic elements of the disease itself; secondly, that studies of the socio-cultural and environmental factors from a larger point of view are essential in understanding the true nature and character of the fundamental disease of schizophrenia and other mental disorders. Certain timeworn ways of determining incidents, prevalence and prognosis have been studied in these terms.

For example, it has been found that first admission rates and patient resident rates are not as reliable as formerly thought. Furthermore, other criteria regarding prognosis, such as clinical types, cannot be used as infallible indices for determining treatment or prognostic features.

In effect, this book attempts to demonstrate that epidemiological methods of research are useful to determine not only the prevalence and incidence of mental illness, but help to determine the nature of the disease along with parallel studies in the areas of biology, biochemistry, and neurophysiology. e. g., it has been found demographically that low educational levels, poor social-economic position, and other factors related to skills at work, and the public values attached to these factors have much to do with the quality and the prevalence of mental disease.

This book is valuable in broadening the concept of mental illness and would be extremely useful, not only to medical students, but particularly to all medical personnel who deal with medical diseases from the total point of view.

Norton Williams, M. D.

FIELD STUDIES IN THE MENTAL DISORDERS. Edited by Joseph Zubin, Ph. D., Columbia University. Grune and Stratton, New York. 1961. $6.75.

This book is a compilation of conferences in seminars conducted by international leaders in the field of psychiatry under the Auspices of the American Psychopathological Association. It is a technical survey on the nature, incidents, course and treatment level of mental illness.

Although the research tone of the book suggests only a beginning study, its implications are far reaching. The book is divided into 4 sections:

The first, on taxonomy, nosology and nomenclature, deals with the importance of clinical agreement of classification terms, symptoms and diagnoses—an area that is strangely confusing and often semantically difficult to both psychiatric student and practitioner.

The second section defines how and why field investigators and source material can be accumulated. It deals with the problems of comparing and statistically evaluating the validity of field investigators.

The third section deals with the actual source material on the epidemiology of mental illness, using such variables as rural-urban, socio-economic, cultural variables, community variables, and other types of social factors.

The fourth section is a summary of all the work accomplished and concrete suggestions for further studies. The main conclusions are as follows: As the organic treatment methods and social institutional treatment forms have become more available and improved, the whole field of mental illness can be increasingly narrowed down to considerations of a more concrete conceptualization of what schizophrenia really is, that is, a more clear-cut idea of what is referred to as nuclear schizophrenia. This is coming back to the original idea that we, as yet, do not fully agree on nor understand the primary nature and symptoms of schizophrenia.

It had been found that most diagnoses and treatment levels had been made for a purpose, rather than as a clinical fact; that is, the diagnosis and treatment has been established for administrative, or legal, or for social reasons, rather than based on the clinical nature of the disease itself.

Another important conclusion was that the diagnosis has been related too closely with specific types of cultural factors. For example, not sufficient inclusion or prognosis had been used in follow-up studies as a basis for the definition of schizophrenia.

One study had indicated that, although the incidence is higher and the prognosis is poorer for lower economic classes than upper classes, high incidence goes with better prognosis when negro-white differences are used culturally. This would indicate, according to the survey, that we have not been sufficiently precise in the type of indicators that we have been using, nor do we fully understand what is referred to as "The whole cause of illness" kind of rating.

A final concrete idea for using military enlistments was suggested as a model for future research. This was based on the high natural disease ratio, the thorough representative sampling, the relatively complete cross-cultural and cross-economic variables, and finally, because of the constant continuous availability of subjects whose later family life could be easily studied, it was thought that this type of field study would be most practical and least expensive. This is a very excellent book that should be available to all those interested in psychiatric research.

Norton Williams, M. D.

THE COMPLEAT PEDIATRICIAN, by Wilbur G. Davison and Jeana Davison Levinthal. Eighth revised edition. Duke University Press. Durham, N. C. 1961. $4.50.

The high regard expressed by reviewers for earlier editions of this most useful handbook for pediatrics must certainly carry on to this new version. Revisions have been fairly frequent and always helpful; the book remains as nearly up-to-date as it is possible for any book to be. Those who have learned to apply the simple system for using the index and references find this manual a valuable and rapid source of information. Those who have not learned the system, should by all means do so.

This is not a detailed reference book in the usual sense, but it steers the reader to sources from which all of their desired information might be obtained. Let us hope that this is a continuing effort and that the *Compleat Pediatrician* will never be fully completed.

J. I. W.

THE ABORTIONIST. By Dr. X as told to Lucy Freeman. Doubleday & Co., Inc. Garden City, New York. 1962. $3.95.

One finishes this book wondering just what it accomplishes. Dr. X, an unidentified professional abortionist, tells his story to Lucy Freeman, who has dipped deeply into the production of books on medical subjects for the layman. How much of this book is Dr. X and how much is Lucy Freeman it is hard to say.

The book emphasizes the fact that a tremendous number of abortions are performed in this country without legal or medical sanction. It points out that in many other countries abortion has a legal status far more lenient than it has in this country, and that here great harm is done by the forced resort to unskilled and untrained abortionists. This is not news, and it is doubtful that the question of the ethical status of the abortionist is one for the medical profession to decide in the face of definite legal, religious, and popular prohibitions.

It is not easy to be too sympathetic with the neurotic character who is the chief figure in this book and who is pictured as a kind of samaritan when the obvious desire for good pay seems to deny the purity of his motives. The physician who can shrug off the loss of a thousand dollars in a robbery must certainly be a man of some wealth. Easy money led him to his first operation and kept him on a successful career for many years, until he was jailed for his performances. Out of jail, he returned promptly to his old mode of living.

This reader is suspicious that the ghost writer has built up a rather doubtful halo for this Dr. X and his kind, and that the introduction of some rather intimate and minute details of the abortionist's technique have been added just to make the book a little bit juicer for the casual reader.

J. I. W.

MEDICINE IN TROPICAL AFRICA, by Michael Gelfand. E. and S. Livingstone, Ltd. Edinburgh and London. 1961. $7.00. The Williams and Wilkins Co., Baltimore, exclusive U. S. agents.

This is not a detailed consideration of medicine in tropical Africa, but rather an introductory review of what one who is not familiar with Africa might look for and expect to find. Neither does it pretend to consider treatment except in casual mention, and it selects only the interesting phases of African diseases without detailed consideration. Parasitic disease is included, but emphasis is placed on the fact that there are many other important and serious diseases among the native Africans.

The South Carolina reviewer is struck by the fact that thirty years ago, barring certain types of parasitic disease, he might have seen in South Carolina many of the conditions mentioned.

The book includes an extraordinary collection of photographs reproduced with greatest clarity.

J. I. W.

STRONG MEDICINE. By Blake F. Donaldson, M. D. Doubleday & Co., Inc. Garden City, New York. 1962. $3.95.

Following an autobiographical introduction, the author takes up the subjects of obesity, heart disease, osteoarthritis, high blood pressure, and allergy, an imposing array of ailments which he thinks may be made to respond happily to reduction of weight by restriction of diet to three meals essentially of meat (with fat) and coffee. Without experience in such efforts, the reviewer must maintain a positive if moderate skepticism and some concern about the lack of consideration of other factors in the diseases mentioned. The use of milk injections in the allergic state have been found to be disappointing by other investigation, but not by our author.

This is a book for lay consumption, unfortunately for the laity. The butchers should like it.

J. I. W.

NEW AND NONOFFICIAL DRUGS 1962. Evaluated by the Council on Drugs of the American Medical Association. J. B. Lippincott Co. Philadelphia. $4.00.

Every years brings a new edition of this very useful, sound, and sometimes disillusioning book. Disillusionment arises from the absence of some of those touted preparations about which we are told in such glowing terms by those who produce them, and a proper disillusionment it is.

The information in this book cannot be duplicated in this handy form anywhere else and a copy of this inexpensive manual is desirable for every therapeutist.

J. I. W.

OUR AMAZING CIVIL WAR

Civil War Oddities

More Americans died during the Civil War than in any other war — and that includes the Revolutionary War, World War II, and the Korean Conflict. Some 700,00 met their death.

Yet this Battle between Brothers accomplished many necessary and worthwhile things. It preserved the Union, and led to a stronger central government. It fostered the industrialization of the South. It produced a folklore, humor, and oddities that still entertain us. It even spread the fame of bourbon!

Civil War Oddities

There were some thirty names for the Civil War, including "Mr. Lincoln's War," "The War to Suppress Yankee Arrogance," and "The Lost Cause."

The Union Army had one company of soldiers made up entirely of prize fighters, another of butchers.

Two of the war's fiercest battles may be said to have been caused by trifles.

1. The battle of Gettysburg began when a few soldiers needed shoes, and their column was sent to that Pennsylvania village for them.

2. A mislaid Army order, which a Confederate officer had used to wrap three cigars in, was found by a Federal officer. The information enabled the usually cautious General McClellan to attack Lee's divided Army at Antietam, Md.

The two foremost best-selling novels in American history have been related to the Civil War— and with conflicting viewpoints. One was Harriet Beecher Stowe's "Uncle Tom's Cabin," and the other Margaret Mitchell's "Gone With the Wind."

General Stonewall Jackson relieved his chronic indigestion with a glass of bourbon, while Yankees were first introduced to that elegant whiskey by Confederates invading Pennsylvania.

For famished Confederate soldiers, one of the most glorious victories of the War came when they raided a Federal Depot af Manassas Junction, and gorged themselves on pickled lobster and canned oysters.

At a siege of Fort Hudson, Miss., Southern quartermasters had to slaughter mules to keep the troops alive. Word of this leaked to the Yankees, who appeared on the river bank next morning braying loudly in imitation of mules.

The Human Side

A lanky man wearing a tall stovepipe hat and dusty suit was halted outside General Grant's tent at the battle of Vicksburg, Miss., and was told that "The General has no time for sanitation officers." The "sanitation officer" was President Abraham Lincoln.

Once General McClellan, who was always asking Lincoln for more troops and supplies but seldom gave battle, demanded more cavalry. Lincoln's patience hit the boiling point and he exploded: "Would you mind telling me what you have done since Antietam that would fatigue your horses?"

When General Robert E. Lee's children were young, he liked to tumble them into bed with him and read stories aloud. They had, however, to take turns tickling the soles of his feet, which he enjoyed. When the little ones tired, or became lost in the tales, Lee would pause and say: "No tickling, no story."

In the heavy firing of the opening battle of The Wilderness in Virginia, a courier who dashed up to Lee with a dispatch was startled to get a scolding for having mistreated his horse by riding so swiftly. Lee then took a buttered biscuit from his saddlebag and fed the hungry animal before turning his attention to the battle.

A legend growing out of the war is that when Lincoln was told that General Grant had a strong taste for Bourbon, the President asked: "What brand of Bourbon? I'd like to send some to my other generals."

Lincoln had apparently never thought of growing whiskers until an 11-year-old girl, Grace Bedell of Westfield, N. Y., wrote him that she and her four brothers would vote for him in the 1860 election if he gave up shaving. "You would look a great deal better for your face is so thin," she wrote. "All the ladies like whiskers and they would tease their husbands to vote for you and then you would be President." Lincoln took her advice and during a campaign stop at Westfield, summoned the little girl out of the crowd and kissed her while people applauded.

Civil War Firsts

The Civil War is credited with a host of "firsts" in American history.

The world's first successful submarine attack was launched by the Confederate "H. L. Hunley," a converted boiler tank bearing a torpedo at her bow and a crew of eight volunteers inside. Six of these men cranked her propeller until a speed of four miles an hour was reached, while she was steered by a compass and crude depth gauge. When the Federal fleet in Charleston Harbor first spotted her, they took her for a porpoise. She sank the sloop "Housatonic" in 1864, but failed to return to port. After the war she was found by Federal divers but they could not move her. To this day she still rests on the bottom of Charleston Harbor, evading modern divers although her location is known!

The Civil War also marked the first railroad artillery, "snorkel" breathing device, land-mine fields, aerial reconnaissance (with gas-filled balloons, flame throwers, working machine gun, and revolving gun turrets.



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Many inventors offered the warring sides ideas bordering on the lunatic, but some of these "brainstorms" forecast the future. One inventor, for example, tried in vain to interest the United States in a rocket-driven torpedo which behaved like a guided missile in its tests.

And the Band Played On

Music was a great morale-booster for both sides. In the early days of the war, Federal armies had half their regiments equipped with bands, and musicians drew higher pay than privates. Union bands, some with as many as 22 pieces, drowned out the smaller Confederate units in a "war of music" on the battlefield. In fact, Southern troops gathered eagerly to listen to enemy bands during the war.

The Yankees applauded a Georgia cornettist at the battle of Atlanta. He serenaded them across the front lines and sang "I Dreamt I Dwelt in Marble Halls" in a fine tenor. The Yanks held their fire and cried for more. The concert over, firing was resumed.

The South was known as "Dixieland," and its stirring anthem was called "Dixie," as the result of a ten dollar bill. In thriving New Orleans with its French heritage, business was conducted with "ten spots" marked in each corner with "Dix," the French word for "ten." To unlettered tradesmen, stevedores, and boatmen, these bills were simply "Dixies," and as their soundness became known in the great river basin, the lower South became "Dixieland."



COOL COURAGE: when Southern troops under Stonewall Jackson marched into Frederick, Md., one patriot defied them by waving the flag of the Union. Her name was Barbara Frietchie. "Shoot, if you must, this old gray head. But spare your country's flag," she said,—according to John Greenleaf Whittier's poem. An angered trooper raised his rifle—but General Jackson stopped him. "Who touches a hair of yon gray head, dies like a dog! March on!" he said. The story is based upon actual fact.

Camphor Poisoning—H. Jacobziner and H. W. Raybin Arch Pediat—Vol. 79:28 (Jan.) 1962

The authors report 8 cases of camphor poisoning in 7 children, 4 months to 7 years of age, and in 1 unmarried pregnant woman 17 years of age. The children had been given mistakenly camphorated oil instead of castor oil or cough medicine by their mothers, or in the absence of the mother had taken the bottle of camphorated oil and swallowed some of its contents. The pregnant woman drank 2 oz. (60 cc.) of camphorated oil with a view toward inducing an abortion. Camphor is used chiefly as a therapeutic agent and as an ingredient of some moth-preventive preparations. Poisoning from camphor occurs chiefly from accidental ingestions and overdoses. Young children and debilitated persons are particularly poor risks and have a low tolerance for the drug. The immediate and most common symptoms of acute poisoning after ingestion are burning in the mouth and throat, thirst, epigastric pain, nausea, vomiting. In severe cases, anxiety, twitching of facial muscles, confusion, spasticity, headache, dizziness, convulsions, hallucinations, depression and coma occur. When death occurs it is usually due to respiratory failure. All the 8 patients recovered. Since there is no specific antidote, the treatment consists of eliminating the camphorated oil from the body by emesis, gastric lavage, catharsis, and diuretics, and otherwise it is chiefly supportive and symptomatic. In case of respiratory distress oxygen and artificial respiration may prove lifesaving. The best treatment is of course total prevention. Nearly all of the cases reported on resulted from the improper storage and handling of the medication. In addition physicians should alert parents that there is no therapeutic value in camphorated oil and its use should be discouraged.

NOTICE
PHYSICIAN'S CLINIC AND EQUIPMENT FOR SALE

Estate of Dr. J. A. Wertz
Estill, South Carolina

Established clinic completely furnished and equipped for immediate sale in Hampton County. Building consists of white and colored reception rooms, secretary's office, walk-in vault, drug room, two doctor's offices, X-ray room, three rest rooms, laboratory, four examining rooms and storage area. Modern brick building with central heating and air conditioning. Large lot with ample parking facilities. 5,000 patient and X-ray records. Equipped with Picker X-ray equipment, new Diapulse machine, photocopy machine, complete surgical instruments, furniture, refrigerator and many other items of equipment and supplies. Sale at fraction of replacement cost. Thriving community near modern hospital. Prefer to sell all intact but will consider separate sales. Reasonable terms.

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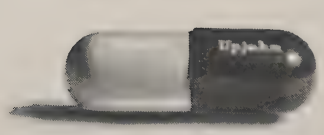
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Side Effects: Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

*TRADEMARK, REG. U.S. PAT. OFF.

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DECEMBER, 1961

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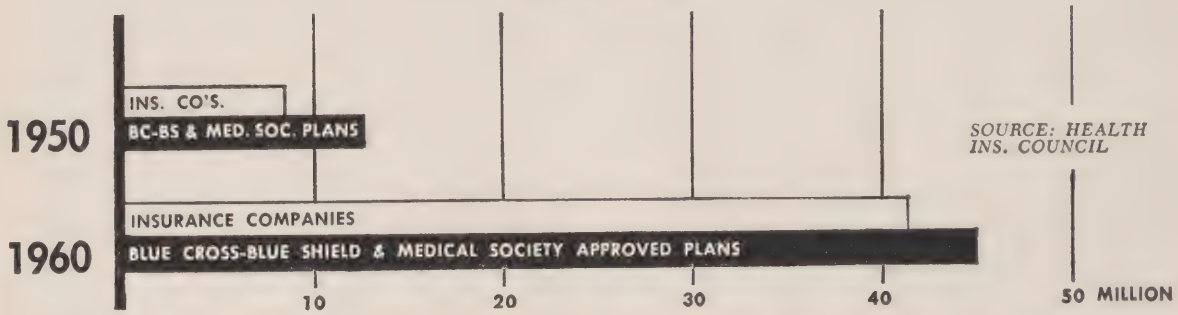
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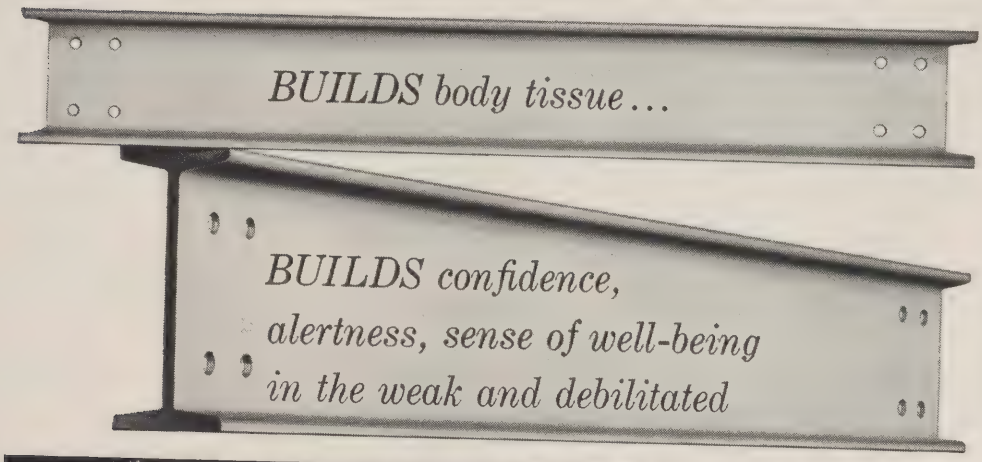
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Dosage: Usual adult dose, one 2 mg. tablet t.i.d. just before or with meals; children from 6 to 12 years, up to 1 tablet t.i.d.; children under 6 years, ½ tablet b.i.d. Available in bottles of 100 tablets.

*animal data

Complete bibliography and literature available on request. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

Winthrop LABORATORIES
1450 Broadway • New York 18, N. Y.

1671M



"Feel any different now, Mr. S.?" *"I thought nothing was happening, Doctor... but then my wife saw a change ...said I wasn't fighting all the time. People at the office seemed easier to work with."* "How about drowsiness?" *"No, not when I need to stay awake."*

this could be your "anxiety patient" on

TREPIDONE®

MEPHENOXALONE LEDERLE

In the treatment of mild to moderate tension and anxiety, the normalizing effect of TREPIDONE leaves the patient emotionally stable, mentally alert. Adult dose: One 400 mg. tablet, four times daily. Supplied: Half-scored tablets, 400 mg., bottle of 50.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



HARTGEL™

(aluminum hydroxide gel, Hart)

Patients with chronic gastritis or peptic ulcer not only need an antacid that is effective and soothing, but one they can live with, happily—for a long time.

HARTGEL is a special formulation providing highest quality *aluminum hydroxide* in a smooth, demulcent, stable suspension, or in convenient-to-carry, easy-to-swallow tablets. Best of all, HARTGEL has a universally appealing, mildly vanilla flavor.

If some of your patients have trouble tolerating peppermint-flavored antacids, this isn't surprising. Oil of peppermint is a local irritant[1], vanilla isn't.

Dose: 1 or 2 teaspoonfuls of HARTGEL liquid or 2 to 4 HARTGEL tablets 5 or 6 times daily between meals and on retiring, or as needed.

Supplied: HARTGEL liquid in bottles of 12 fluidounces, tablets in strip-packs of 100 or bottles of 1,000.

Also available: HARTGEL HMB (suspension and tablets) containing HARTGEL, homatropine methylbromide and phenobarbital for control of tension and spasm associated with gastric hyperacidity.

1. Sollmann, Torald: A Manual of Pharmacology, W. B. Saunders Company, Philadelphia, 1957, p. 202.

HART LABORATORIES, *Division of A. J. Parker Co.*, Winston-Salem, N.C.



a relaxed mind in a relaxed body

with

Trancopal®

Brand of chlormezanone

effective TRANQUILIZER ■ potent MUSCLE RELAXANT

When you prescribe Trancopal you can see how this "tranquilaxant" speedily helps the anxious patient. It quiets his psyche — and this quieting helps relax tense muscles. It eases muscle spasm — and this easing helps put the mind at rest.

DeNyse[1] notes that the effect of Trancopal as a quieting agent ". . . may play a part in the skeletal muscle relaxing results obtained." Gruenberg[2] used Trancopal to treat patients with musculoskeletal disorders, and commented: "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."

Trancopal has an unsurpassed record of safety. Very few side effects occur with Trancopal. You may see them in only about two out of a hundred patients, and they will almost always be mild.

Available: 200 mg. Caplets® (green colored, scored), bottles of 100
100 mg. Caplets (peach colored, scored), bottles of 100

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily;
children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

Winthrop LABORATORIES New York 18, N.Y.

1649M



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, *fast!*

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

This was demonstrated by Kestler in a controlled study: average time for full recovery was 11.5 days with Soma, 41 days without Soma. (J.A.M.A. **172**:2039, April 30, 1960.)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets.
USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

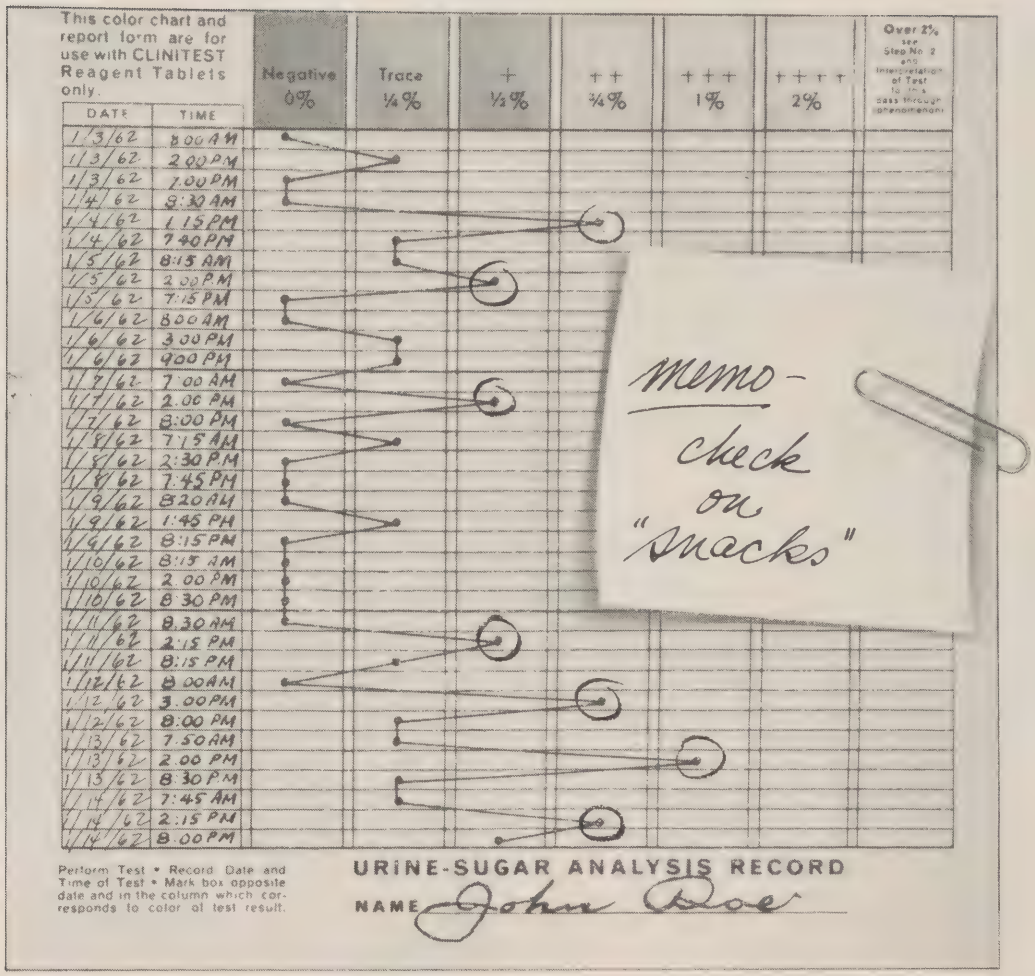
SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

AN AMES CLINIQUICK®

CLINICAL BRIEFS FOR MODERN PRACTICE



in the regulation of diabetes...
GET THE FACTS YOUR PATIENT FORGETS

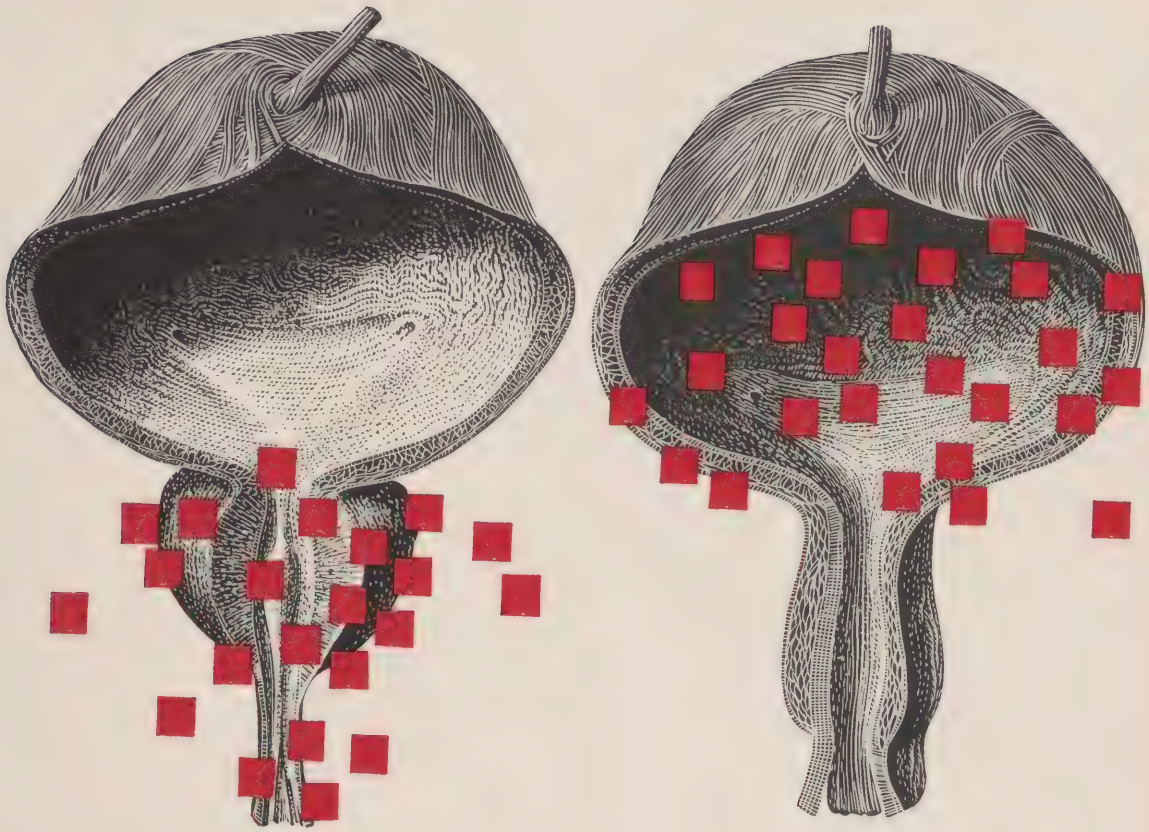
With graphic ANALYSIS RECORD—"Records of urine tests done at home are essential in the regulation of diabetes." Ricketts, H. T., and Wildberger, H. L.: *Diagnosis and Management of Diabetes Mellitus in General Office Practice,* M. Clin. North America *45*:1505, 1961.

color-calibrated CLINITEST® BRAND *Reagent Tablets*

quantitative urine-sugar test—for patients whose diabetes is difficult to control, and in therapeutic trial of oral hypoglycemic agents.

Available: CLINITEST *Urine-Sugar Analysis Set* (36 Reagent Tablets)—compact, ready-to-test any time, any place. Set, refills of 36 bottled and 24 Sealed-in-Foil tablets contain *Analysis Record* forms. 19962

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Squibb Ethoxazene (Diamino-Ethoxy-Azobenzene Hydrochloride)

Quickly eliminates pain and burning in the lower urinary tract

At real savings to your patients

Serenium provides **quick, localized analgesic action** in acute and chronic urinary tract infections with **only 1 tablet** t.i.d. Your patient is assured of the prompt action of Serenium by the harmless orange-red color of the urine; and he will feel good about the **low prescription cost,** too.

Supply: Bottles of 50 and 500 chocolate-covered tablets. Each tablet contains 0.1 Gm. of Squibb Ethoxazene. For full information see your Squibb Product Reference or Product Brief.

Serenium® is a Squibb trademark.

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The Hospital is located in a 75-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

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Organon

An important announcement to physicians who prescribe corticosteroids

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This new product is being marketed under the trade name of HEXADROL, brand of dexamethasone 'Organon'. HEXADROL is now being offered to your pharmacist at a price which should make it available to your patients at a cost well within the price range of older generically prescribed corticosteroids. It is supplied as 0.75 mg. white scored tablets, in bottles of 100.

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For complete information concerning HEXADROL—including indications, dosage, precautions and side effects—or if you would like a trial supply, ask your Organon Representative, or write to: Director, Professional Services, Organon Inc., West Orange, N. J.

'Organon'—your professional assurance of quality
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Day and night– less wheezing, coughing, labored respiration in chronic bronchitis and emphysema

New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal® (brand of phenobarbital)	6 mg.
Alcohol	19%

Adult Dose: 2 tablespoons 3 or 4 times daily.

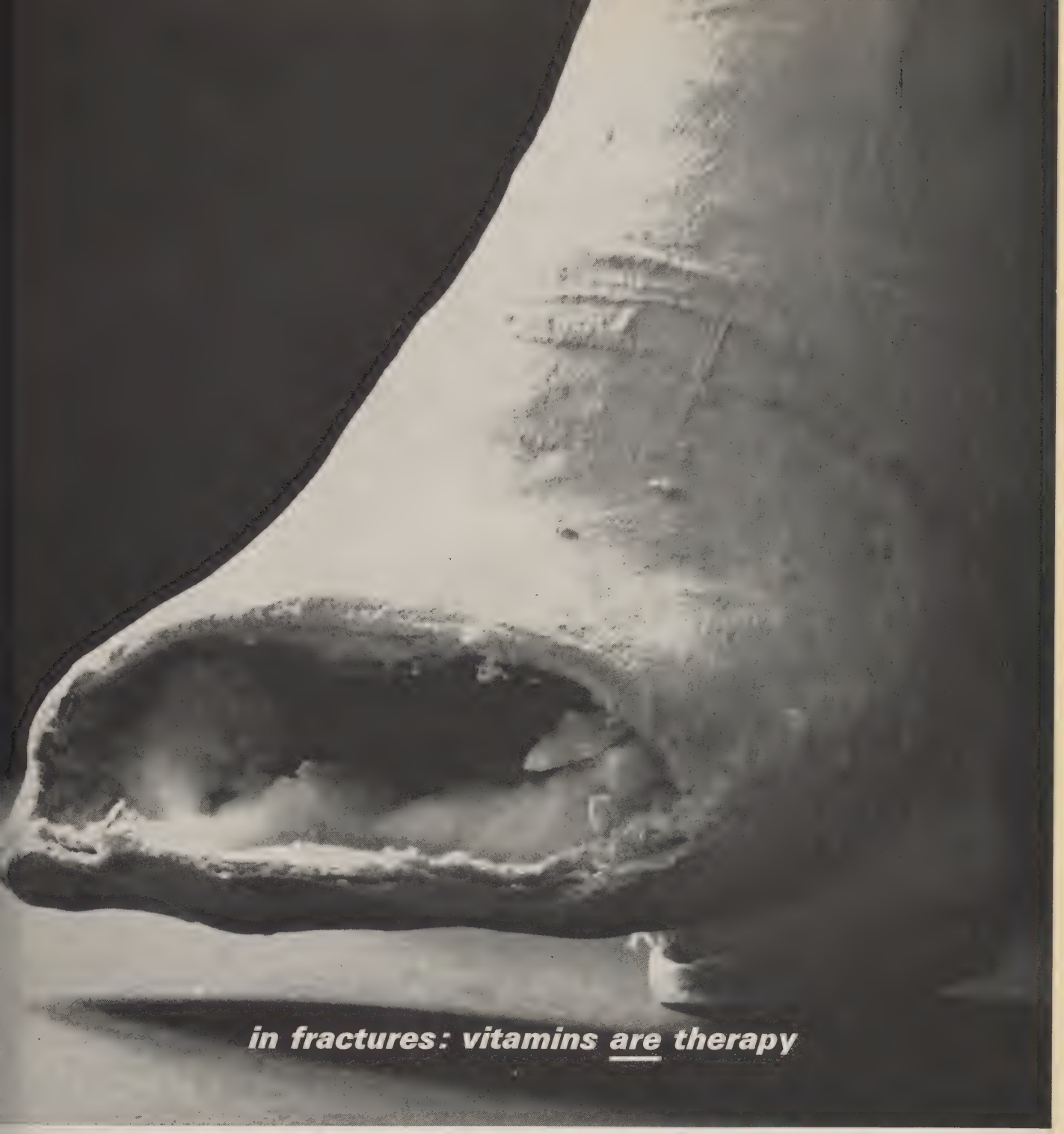
How Supplied: Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

New ISUPREL® compound ELIXIR

Winthrop LABORATORIES
New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

STRESSCAPS®

Stress Formula Vitamins Lederle



Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

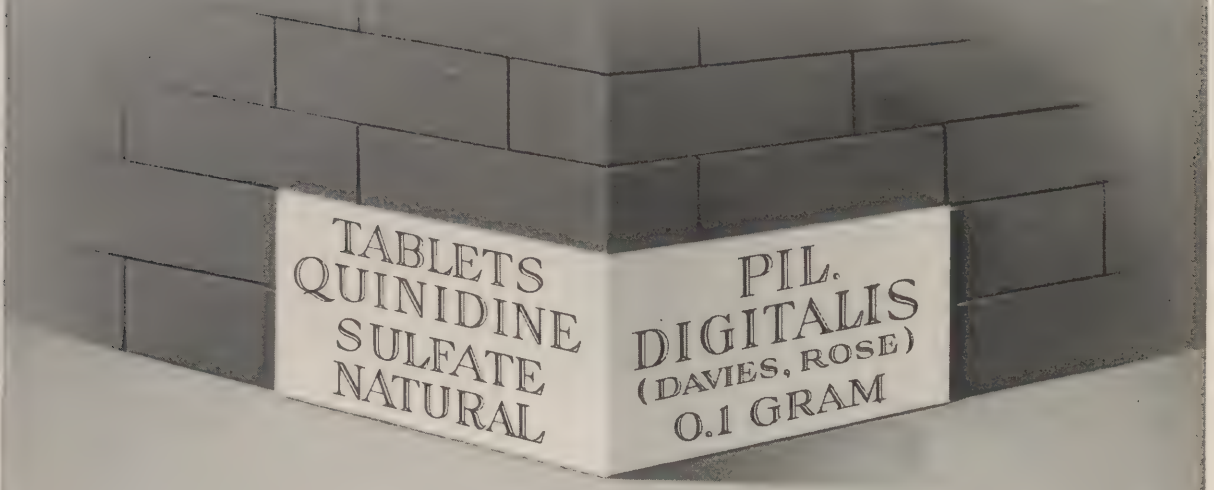
For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

When you suggest to your patients that they have a big glass of orange juice for breakfast, or for a snack, or when they want to raid the refrigerator, the deliciousness of Florida orange juice will give you assurance that they'll *want* to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

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A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

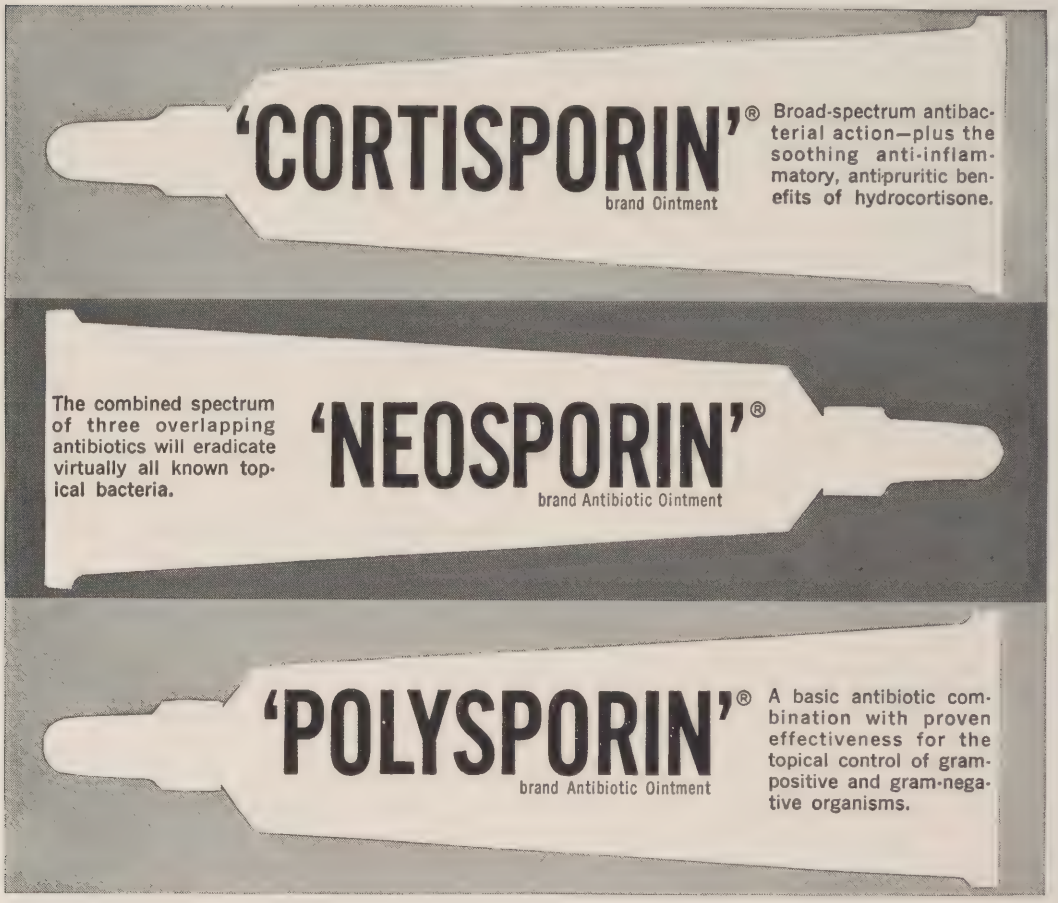
Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

Davies, Rose & Company, Limited - Boston 18, Mass.

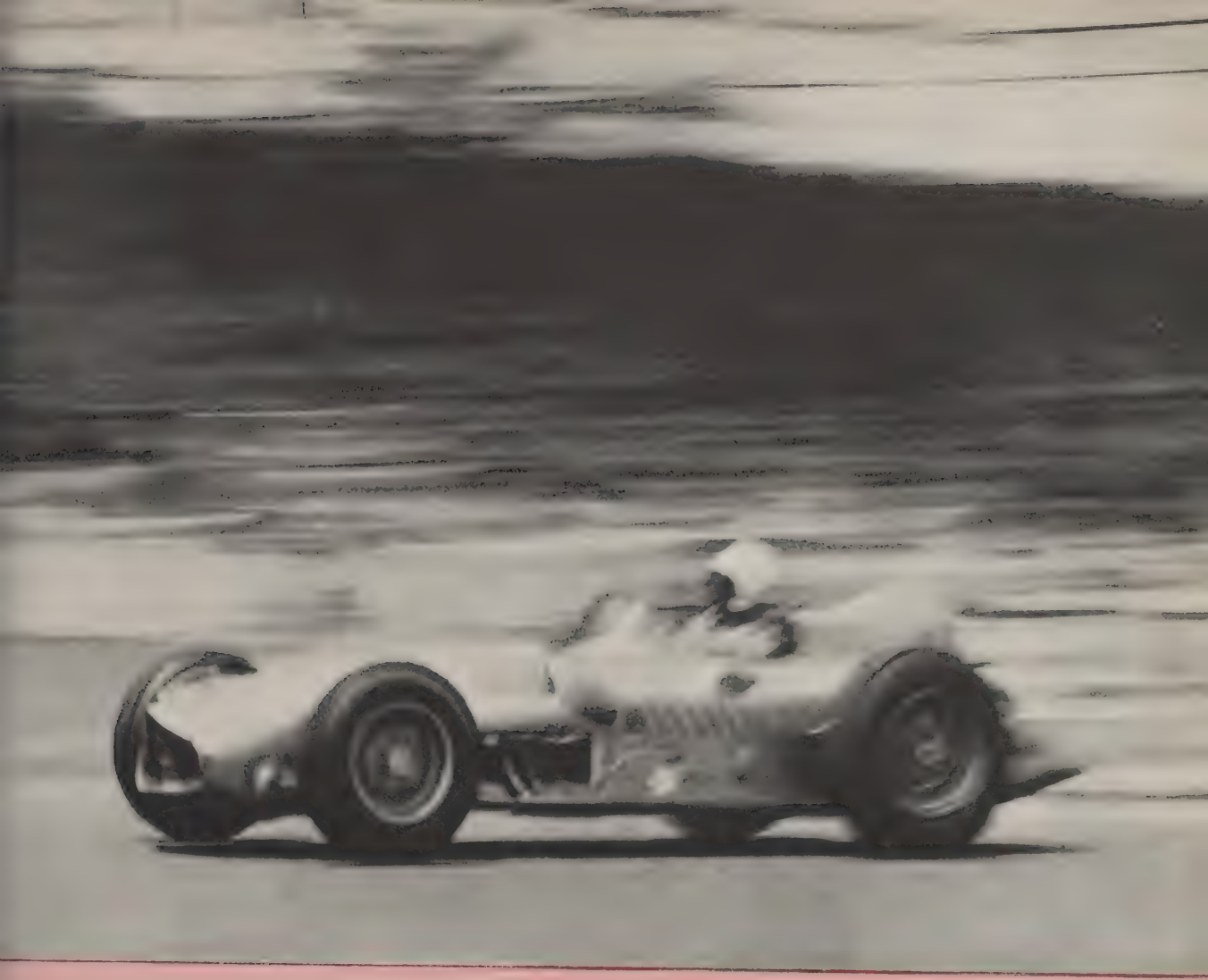
DQ-2

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

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in the wide middle region of pain

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fills the gap between mild oral and potent parenteral analgesics

■ acts in 5-15 minutes ■ relief usually lasts 6 hours or longer ■ constipation rare ■ sleep uninterrupted by pain

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AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law allows oral prescription. *Also Available:* Percodan®-Demi: the complete Percodan formula, but with only half the amount of salts of dihydrohydroxycodeinone and homatropine.

Each scored, yellow Percodan* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl, 0.38 mg. dihydrohydroxycodeinone terephthalate (warning: may be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

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Acetylsalicylic acid, 5 gr.
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Simultaneous action beginning promptly
lasting four or five hours

Synirin was formulated
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May be repeated every four hours
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brand of chlorpromazine

A fundamental drug
in both office and hospital practice

Posed by professional models.

For prescribing information, please see PDR or SK&F literature.



"All the world's a stage..
And one man in his time
plays many parts,
His acts being seven ages..."*

*As You Like It, Act II, Sc. 7

through all seven ages of man

VISTARIL®

effective anxiety control with a wide margin of safety

in the "frantic forties"—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

In each of these areas, VISTARIL is often effective alone or as an adjunct to other therapy. For example, in his series of 67 patients, King[1] found that 62 showed remission of anxiety, tension, nervousness and insomnia, as well as alleviation of symptoms associated with various functional and psychophysiological disturbances. He concludes that VISTARIL is well suited for use in the practice of internal medicine.

In the emergent situation, VISTARIL, administered parenterally, is a valuable aid to the physician in managing patients who escape psychic conflict via alcohol. According to Weiner and Bockman,[2] who obtained beneficial results in 81% of 175 patients studied, hydroxyzine (VISTARIL) may well be considered a tranquilizer of choice in the management of the acutely agitated alcoholic.

1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

VISTARIL® CAPSULES AND ORAL SUSPENSION
HYDROXYZINE PAMOATE

VISTARIL® PARENTERAL SOLUTION
HYDROXYZINE HYDROCHLORIDE

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IN BRIEF VISTARIL®

VISTARIL, hydroxyzine pamoate (oral) and hydroxyzine hydrochloride (parenteral solution), is a calming agent unrelated chemically to phenothiazine, reserpine, and meprobamate.

VISTARIL acts rapidly in the symptomatic treatment of a variety of neuroses and other emotional disturbances manifested by anxiety, apprehension, or fear–whether occurring alone or complicating a physical illness. The versatility of VISTARIL in clinical indications is matched by wide patient range and a complete complement of dosage forms. The calmative effect of VISTARIL does not usually impair discrimination. No toxicity has been reported with the use of VISTARIL at the recommended dosage, and it has a remarkable record of freedom from adverse reactions.

INDICATIONS: VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

ADMINISTRATION AND DOSAGE: Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.–50-100 mg. Stat., and q.4-6h., p.r.n. I.V.–50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

SUPPLIED: VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)–10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)–25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)–25 mg. per 5 cc. teaspoonful.

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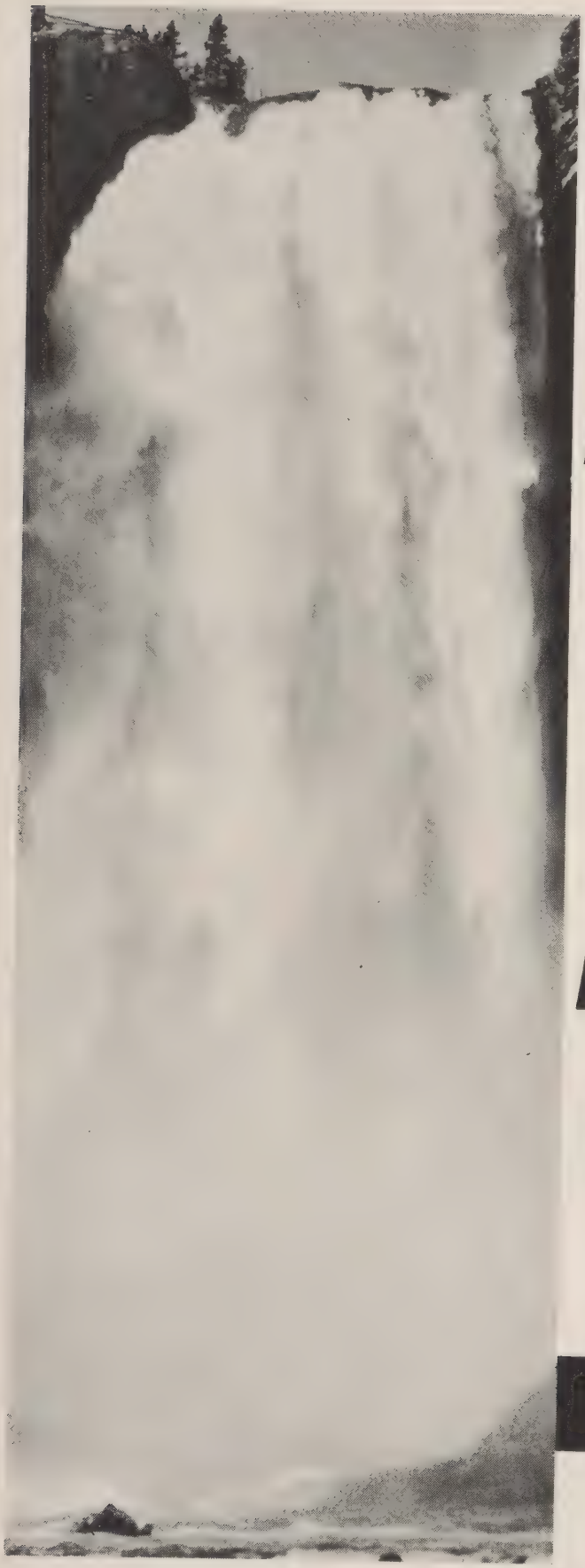
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Today when the recovered mental patient leaves the hospital, the mental health association is by his side to help him find a job, new friends, follow-up medical care. **Support your mental health association.**

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PROVIDES 10 - 12 HOURS GRADUAL RELEASE . . .

Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate . . . a clinically proven dosage form. For assured 24 hour control, administer one Antora capsule before breakfast and one before evening meal. ANTORA REDUCES NITROGLYCERIN REQUIREMENTS . . . IMPROVES EKG TRACINGS . . . PROVIDES BETTER EXERCISE TOLERANCE . . . REDUCES NUMBER AND SEVERITY OF ATTACKS. Administer with caution in glaucoma.

FOR THE UNDULY APPREHENSIVE PATIENT . . .

ANTORA-B...

Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate plus 50 mg. Secobarituric Acid. Medication is released over 10 to 12 hours with fewer side effects and less "hangover" than the longer acting barbiturates. As with Antora, capsules are administered only twice daily instead of the usual 8 to 12 tablets. Administer with caution in glaucoma.

REFER TO PDR

PAGE 643

Supplied: Bottles of 60 and 250. Literature and clinical samples available.

Mayrand, inc.

PHARMACEUTICALS

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GREENSBORO, NORTH CAROLINA

PHYSICIAN'S DISABILITY INCOME

APPROVED
FOR MEMBERS OF
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SICKNESS OR ACCIDENT
(MONTHLY BENEFITS)

For total disability from accident:
MONTHLY BENEFIT FOR LIFE--$300.00
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MONTHLY BENEFIT first
12 months ----------$300.00
—thereafter—
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(up to 3 months for sickness or accident)

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$100.00 ADDITIONAL MONTHLY BENEFIT FOR TOTAL DISABILITY for as long as one year is available by rider.

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Disability Benefits begin with first day of disability and medical attention.
Pays total disability income benefits for life—covering both accidents and sickness.
There is no time limit or aggregate as to total disability payments.
House confinement is not required.
Covers accidental bodily injury on the policy date and sickness originating more than 30 days thereafter.
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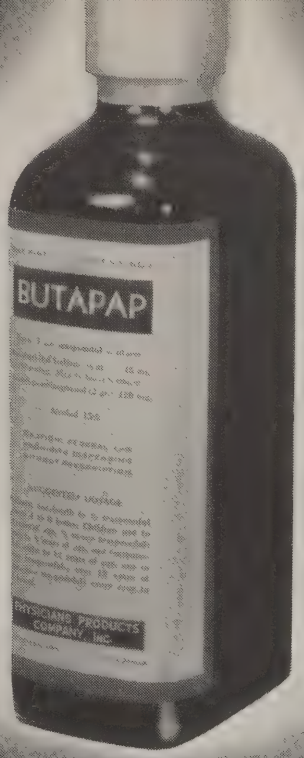
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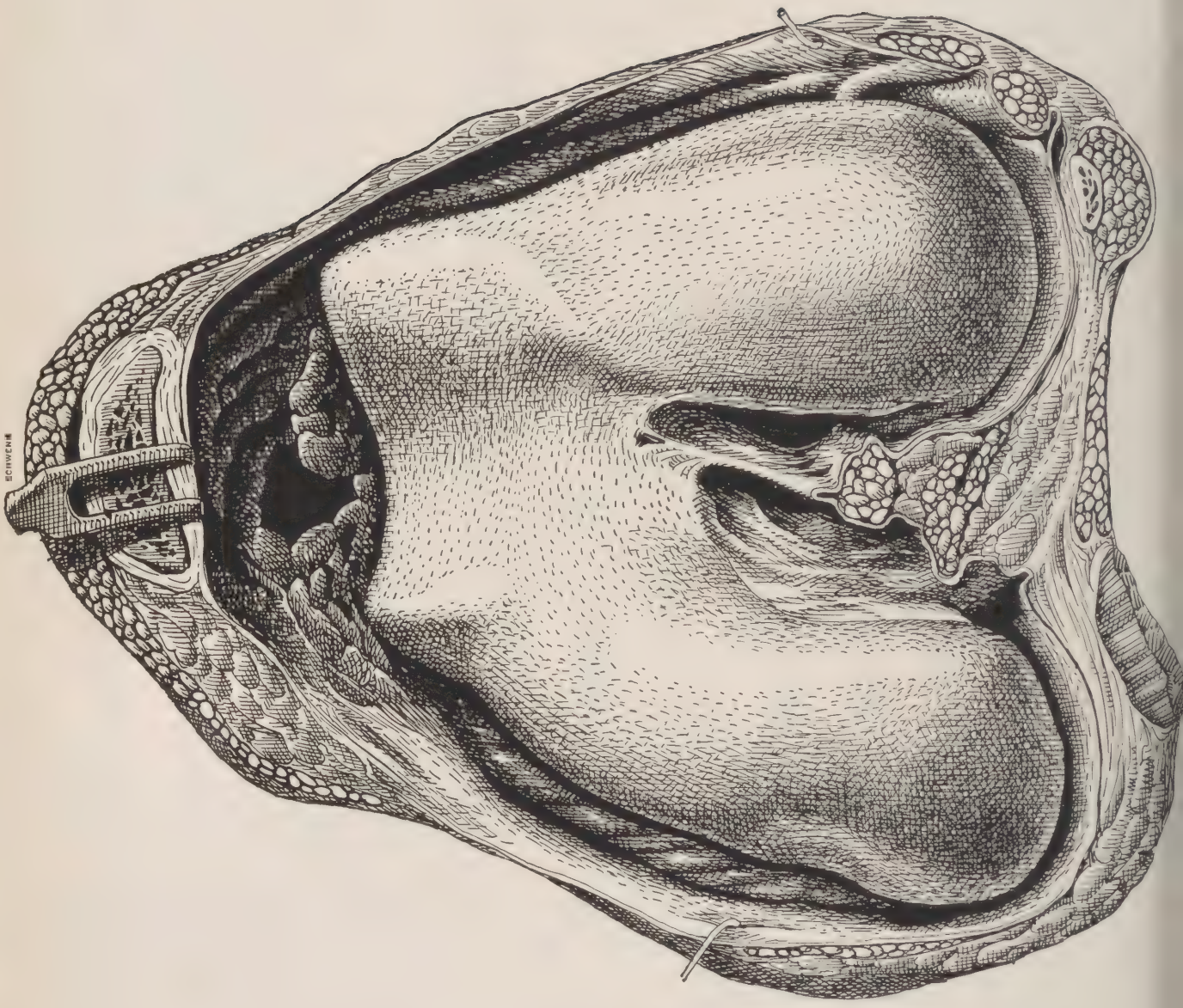
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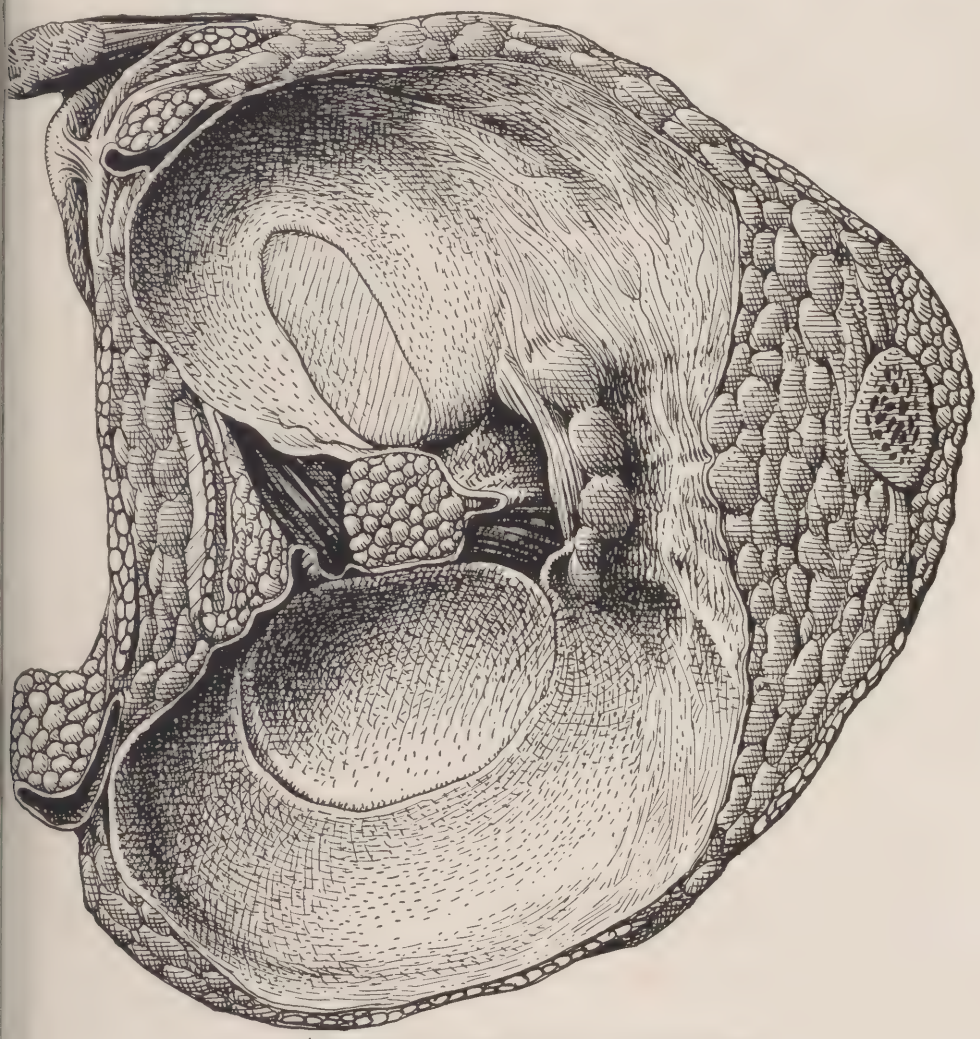
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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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REFERENCES: (1) Roseman, E.: Neurology 11:912, 1961. (2) Bray, P. F.: Pediatrics 23:151, 1959. (3) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (4) Crawley, J. W.: M. Clin. North America 42:317, 1958. (5) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (6) Ibid.: Postgrad. Med. 20:584, 1956. (7) Merritt, H. H.: Brit. M. J. 1:666, 1958. (8) Carter, C. H.: Arch. Neurol. & Psychiat. 79:136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (10) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

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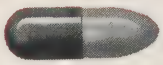
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*Schwartz, I. R..
Current Therap. Res. 3:29, Feb., 1961.

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JUNE, 1962 — VOL. 58, NO. 6

CONTENTS

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ORIGINAL ARTICLES

Operative Treatment of Biliary Tract Disease—*R. Randolph Bradham, M. D. and G. S. Nettles* ---- 207

Swelling of the Arm After Radical Mastectomy (Treatment by Intermittent Compression)—*William H. Prioleau, M. D.* ---- 211

Patients Are People—*J. Decherd Guess, M. D.* ---- 214

Comparative Study of Anticoagulants for Long-Term Use—Acenocoumarol vs. Warfarin—*Richard S. Pollitzer, M. D., William N. Cochran, M. D. and H. Grady Williams, M. D.* ---- 217

MEDICAL COLLEGE CLINICS

Dermatological Don'ts—Contact Dermatitis—Poison Ivy—*Kathleen Riley, M. D.* ---- 220

EDITORIALS

Annual Meeting Held ---- 221
Anti-Prophylaxis ---- 221
F. B. I. ---- 221

FEATURES

Address of the President—*Charles N. Wyatt, M. D.* ---- 222
Minutes of Council Meeting, Feb. 7, 1962 ---- 224
News ---- 225, 238
Blue Cross . . . Blue Shield ---- 228
Deaths ---- 229
Civil Defense ---- 230
Public Relations ---- 231
Prize Essay on Free Enterprise—Carolina Clower ---- 237
Book Reviews ---- 240

Contributions of Original Articles

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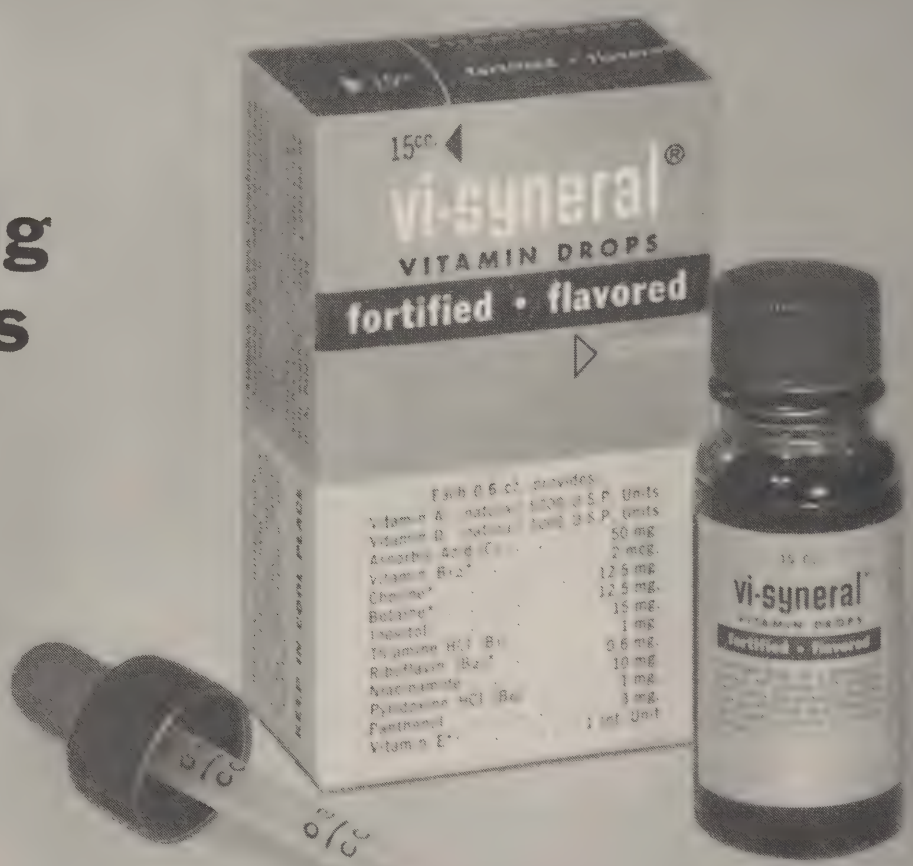
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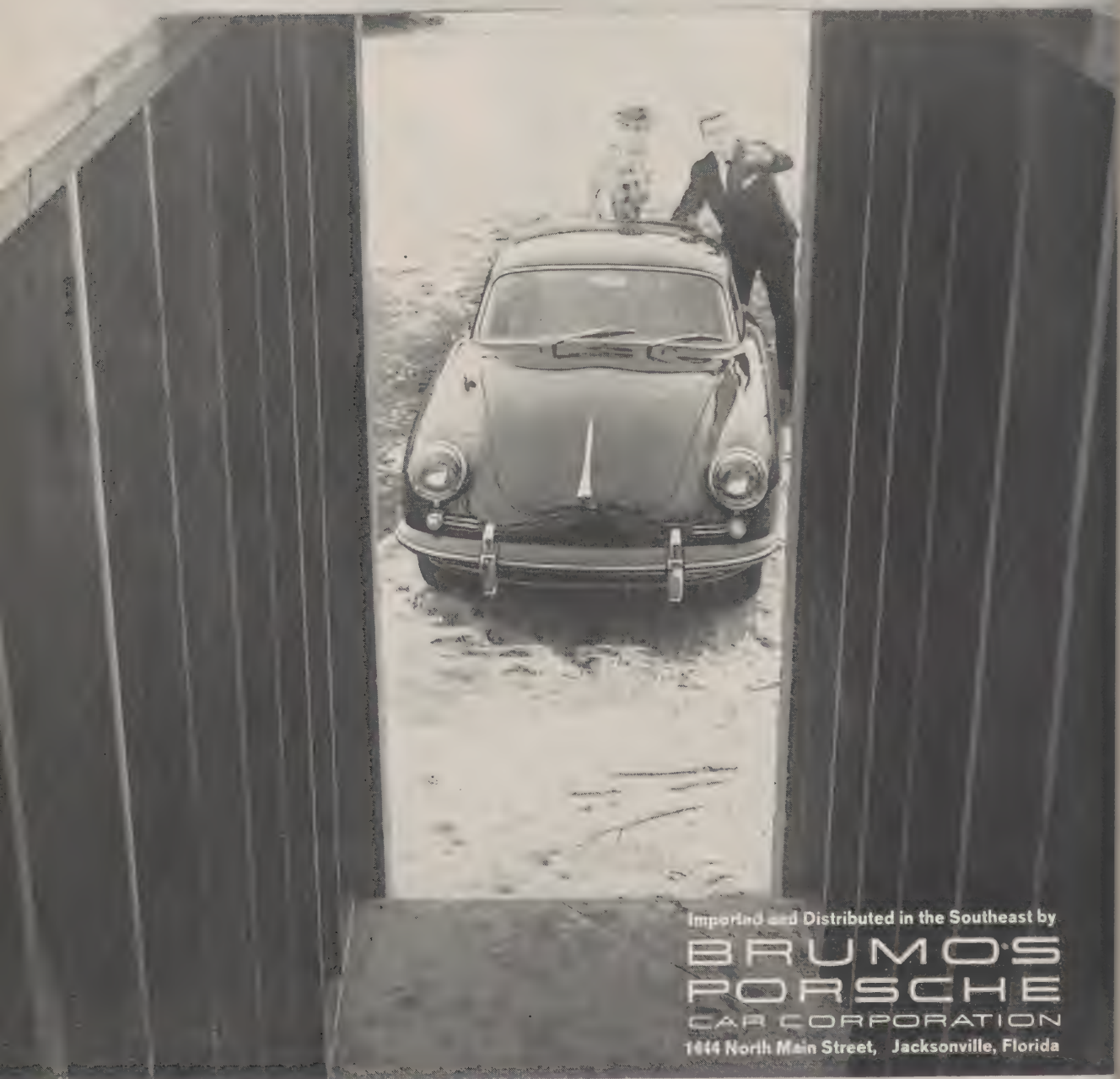
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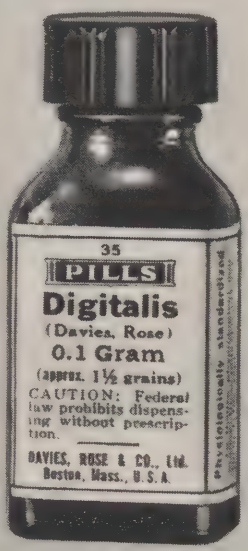
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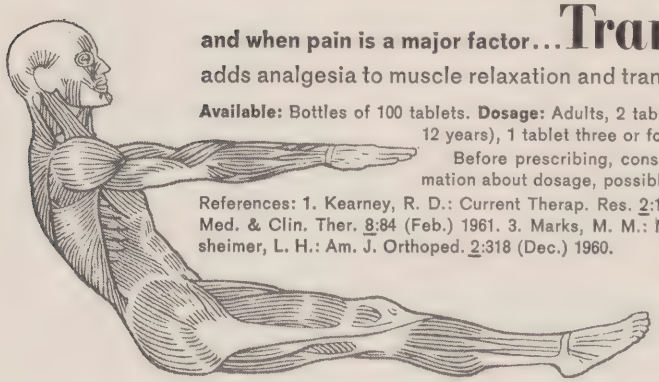
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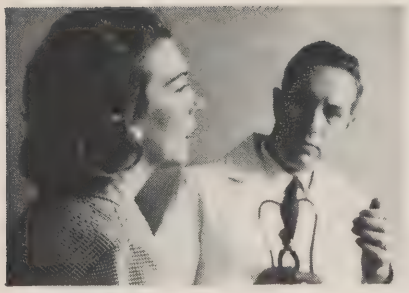
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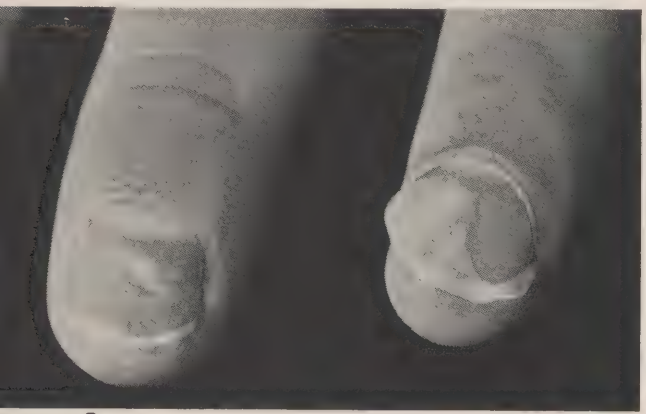
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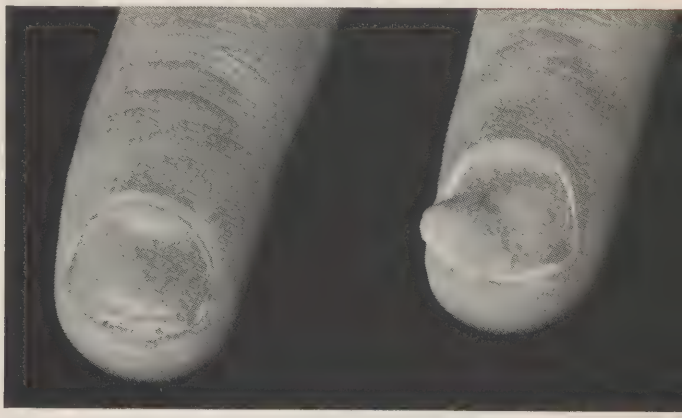
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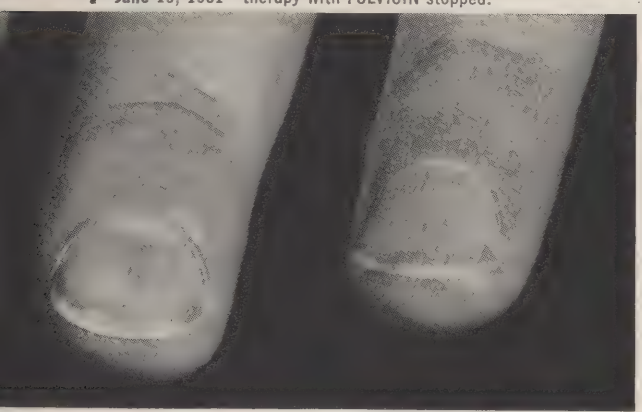


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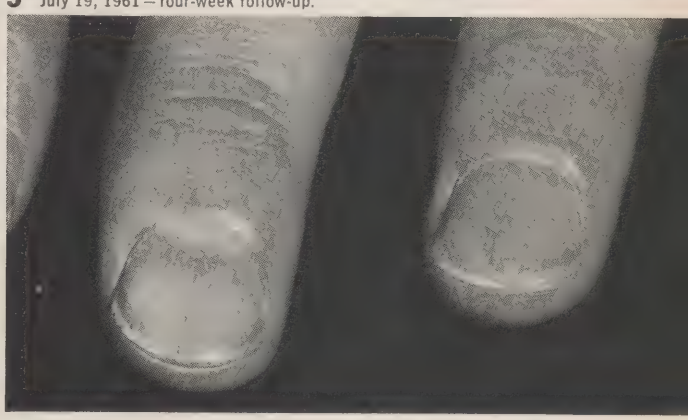
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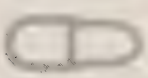


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The Journal
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VOLUME 58 June, 1962 NUMBER 6

OPERATIVE TREATMENT OF BILIARY TRACT DISEASE

R. RANDOLPH BRADHAM, M. D.
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Associate Professor of Surgery
Clinical Research Assistant, Department of Surgery

While management of gallbladder disease has improved progressively during the past several decades, there is still much to be learned about the management of this benign disease. Only by continuing to evaluate the methods of treatment can surgeons gain the judgement that is necessary to reduce the mortality and morbidity that now exist. Removal of calculous gallbladders before complications ensue, more accurate evaluation of the common bile duct at operation, and better selection of patients for planned cholecystostomy are all factors which should help approach this goal. This presentation is a modest record of the experience in our own institution.

Material

The present series comprises those patients treated operatively for extrahepatic biliary tract disease at the Medical College Hospital of the Medical College of South Carolina from September, 1955, to May 1, 1961. Many different attending and resident surgeons participated in the care of these patients. There were 216 patients upon whom 226 operations were performed. The operations are listed in Table 1. One hundred and fifty-two patients were female and 64 were male. The ages ranged from 10 to 89 years. The majority, 65%, were between 40 and 70 years of age.

TABLE I

Operation	*No. of Patients*
Cholecystectomy	140
Cholecystectomy, Choledochotomy	46
Cholecystectomy, Choledochotomy, duodenotomy	18
Cholecystostomy	18
Choledochotomy	2
Choledochotomy, duodenotomy	1
Cholecystectomy, choledocho-jejunostomy	1

Calculous cholecystitis was present in 187 (91%) of 205 patients having cholecystectomy. Of the 18 gallbladders not containing calculi, three were removed for carcinoma invading from another organ, one for a gallbladder polyp, one for primary gallbladder carcinoma, and the other for chronic pancreatitis with pseudocyst formation. The latter was done concomitantly with a cystojejunostomy.

From the Department of Surgery, Medical College of South Carolina, Charleston, South Carolina.

Common duct stones were found in 15 (33%) of the 46 patients having cholecystectomy and common duct exploration and in 6 (33%) of the 18 patients having cholecystectomy, choledochotomy, and duodenotomy. Two patients had choledochotomy alone. Calculi were found in one. In the other case, the duct was explored for hemobilia caused by T-tube erosion. No calculi were found in the single patient having choledochotomy and duodenotomy. This patient was jaundiced secondary to pancreatitis occurring following gastrectomy. The one cholecystectomy and choledochojejunostomy was done for a patient who had a 2 centimeter stricture of the distal common duct believed to be the result of cholangitis. All of the common ducts explored, except three, were drained postoperatively by an indwelling catheter or T-tube.

Cholecystostomy was performed on 18 patients. Fourteen of these patients were ill with acute cholecystitis. Three were done for complications of chronic cholecystitis noted during operation for malignant disease of another organ. One was done merely to relieve jaundice in a patient who was extremely ill with carcinoma of the pancreas. The one death in this group occurring in a patient with acute cholecystitis is discussed below. Of the 13 other patients having acute cholecystitis, 9 have subsequently had cholecystectomy electively. Three patients have been asymptomatic for from one to three years and have not consented to cholecystectomy. One patient subsequently died of carcinoma of the esophagus.

Postoperative complications occurred in nine patients. There were five wound infections, one subphrenic abscess, one case of thrombophlebitis, one wound dehiscence, and one instance of hemobilia secondary to erosion by a T-tube.

Four patients died. Brief accounts are as follows:

1. L. M. was a 79 year old female admitted with a history of severe vomiting for one week. Previously, she had sustained a cerebrovascular accident and a myocardial infarction. There was complete gastric outlet obstruction due to cicatrix. This was corrected at operation with a gastrojejunostomy. A cholecystostomy was done concomitantly to relieve a distended, sub-acutely inflamed gallbladder. She died suddenly on the first postoperative day from a massive myocardial infarction.

2. R. M., a 65 year old male, was operated upon for obstructive jaundice and weight loss. Far advanced carcinoma of the pancreas and a greatly distended gallbladder with focal areas of necrosis in the fundus were found. Choledochojejunostomy was not feasible. The gallbladder was removed and the common duct drained via a catheter. He died in the late postoperative period following a progressive downhill course.

3. H. O., a 42 year old male, was admitted following an acute illness of five days duration manifested by severe abdominal pain, fever, vomiting, and jaundice. There was a past history of cardiac decompensation with arteriosclerotic heart disease. Prior to operation supportive therapy including digitalis, electrolytes, fluid, and whole blood was administered. At operation, perforated empyema of the gallbladder, multiple intraperitoneal abscesses, and multiple liver abscesses communicating with the gallbladder were found. Several hours following cholecystectomy and drainage of the abscesses, he died of cardiac arrest despite vigorous resusitative efforts.

4. C. C., a 57 year old male, was admitted following an illness of three weeks associated with abdominal pain, fever, and weight loss. At operation chronic cholecystitis and pancreatitis were found. Cholecystectomy, choledochotomy, and duodenotomy were done. Wound dehiscence occurred following tracheal catheterization necessary to relieve atelectasis. Death occurred suddenly 24 hours following closure of the wound. An autopsy was not granted.

Discussion

The series of cases presented is certainly a modest one. However, experience gained during this five year period has given clarification to certain principles of treatment that should enhance our management of patients with biliary tract disease in the future.

Acute Cholecystitis:

No standard or set policy has been followed in the treatment of acute cholecystitis as there is varied opinion on our own staff regarding early versus delayed operative treatment. The management of any given case is the responsibility of the attending surgeon on the particular ward to which the patient is admitted. In general, the policy of a "cooling off" period has been followed if the inflammatory disease is not advanced and if there is progressive improvement following admission. Operative therapy is given at any time an unsatisfactory course is indicative of progression of the disease. When the acute phase has subsided, a thorough evaluation of the gastrointestinal tract is made. If gallbladder disease is veri-

fied, the patient is urged to return for elective cholecystectomy.

In this series, 27 patients were operated upon when the disease was acute. Fourteen patients had cholecystostomy and 13 patients had a cholecystectomy. The high percentage of patients having cholecystostomy as the initial operative treatment was in part due to delay in referral to the hospital until the disease became advanced. Cholecystectomy is certainly the most satisfactory procedure if this can be accomplished without undue hazard to the patient. If the patient is extremely ill, or if there are other conditions present which would increase the operative risk, a cholecystostomy is planned preoperatively and performed with local anesthesia through a small transverse incision. This has been the subject of another report.[1]

No conclusions can be drawn from this study which would support delayed operative treatment in preference to early operation. There are, however, factors which make the delayed operative treatment reasonable. The diagnosis of acute cholecystitis is sometimes difficult to make. It is not unusual to find, by intravenous cholangiography, a normally functioning gallbladder in a patient considered to have acute cholecystitis. In a careful review of the hospital records of 338 patients discharged from the University of Michigan Hospital with a diagnosis of acute cholecystitis, Buxton, Ray, and Coller[2] found only 109 of these patients suitable candidates for this diagnosis.

Perforation of the gallbladder, especially the Niemeier type 2, where there is formed a pericholecystic abscess, is certainly a complication to be feared while observing a patient suspected of having acute cholecystitis.[3] To be a deterrent to the "cooling off" period favored by the author, perforation would have to occur in a significant number of cases while under observation and be associated with an increased morbidity and mortality. It is doubtful that this is true when patients are followed carefully with frequent examinations and when operation is performed with progression of the disease. Massie, Coxe, Parker, and Dietrick[4] found 13 perforations in 328 patients having acute or sub-acute cholecystitis. There was one death associated with a type 2 perforation. They concluded that perforation may occur in an occasional patient in the hospital while "cooling off" but that early hospitalization would minimize this danger. McCubbrey and Thieme[5] reviewed 16 cases of perforation. It was their opinion that although perforation with abscess formation is a consideration in the treatment of acute cholecystitis, it is questionable that a program of early operative treatment would lower the mortality associated with pericholecystic abscess. Strohl, Diffenbaugh, Baker, and Cheema[6] have recently made an excellent review of this subject.

If an initial period of observation is chosen, the principles of nonoperative treatment as outlined by Becker, Powell, and Turner[7] must be rigidly followed. These include:

(a) correction of fluid, electrolyte, and blood volume deficits.
(b) nasogastric suction for gastrointestinal tract rest.
(c) alleviation of pain and apprehension.
(d) prevention and treatment of infection by antibiotics.
(e) careful and frequent evaluation of the patient.
(f) operative treatment if course is unsatisfactory.

Chronic Cholecystitis

Symptomatic chronic cholecystitis and asymptomatic gallstones are indications for elective cholecystectomy in patients who are reasonably good operative risks. Lund[8] obtained an almost 100% complete 5 to 20 year follow-up on 526 primarily non-operated cases of calculous cholecystitis. One half of these patients later developed either severe symptoms or complications or both. One third of them developed complications alone. The duration of the symptoms, prior to diagnosis, proved to be of no significance to the future course. The prognosis for those with asymptomatic stones was comparable to that for the symptomatic group. Fourteen patients died of gallstone disease, the mortality increasing with advancing age. In an undetermined number of the other patients, a fatal course was prevented by operation.

Glenn and Guida[9] emphasized the impor-

tance of the prevention of further damage to the liver and biliary tract that is interrupted by cholecystectomy. They likewise believed it pertinent that the sequelae and complications of long standing calculous disease, that are associated with a high morbidity and mortality, are prevented.

There is much support for elective cholecystectomy in a reasonably good risk patient, regardless of age. Emergency operations in the older age group carry a much higher mortality than elective procedures. Babcock and Eyerly[10] reported a mortality of 10.5% in 85 patients over 50 years of age and only 1.6% in 62 patients under 50 years of age who were operated on for acute cholecystitis. dePeyster and Gilchrist[11] reported on 73 operations for biliary tract disease done on 63 patients who were 70 years of age and older. The mortality rate in 64 elective operations was 4.7%. In the 9 patients having emergency operations, the mortality was 22.2%. Becker, Powell, and Turner[7] reported a mortality of 2% in patients under 60 years of age and 16% in patients over 60 years of age who had operations for acute cholecystitis. Stahlgren,[12] in a study of patients over 69 years of age having abdominal operations, found the mortality to be two and one half times higher in those having emergency procedures than in those having elective operations.

The usual indications for common duct exploration were followed in our cases. Operative cholangiography has become more popular among our staff and is used routinely by the authors. If there are not good indications for exploring the common duct, a small polyethylene tube is inserted through the cystic duct stump into the common duct and a cholangiogram obtained. If the duct is explored, cholangiograms are done through the T-tube before the incision is closed. Calculi have been found in several ducts by this method which were not found on exploration. This is a good adjunct to biliary tract surgery and if used routinely can be done with facility. Hight, Lingley, and Hurtubise[13] found a greater surgical error than operative cholangiogram error in finding stones in the common duct when two groups of patients were compared, one group having exploration as the initial evaluation and the other having cholangiogram prior to exploration. They concluded that although cholangiograms are not infallible, they are considerably more reliable as a guide to common duct exploration than the usual indications. Saypol[14] has increased his accuracy in finding stones in the common duct to near 100% by developing a meticulous method of palpating the extra-hepatic biliary system throughout its course. This included mobilizing the duodenum and head of the pancreas to facilitate palpation of the lower portion of the duct. If no stones are palpated, a cholangiogram is done to confirm the findings by palpation. It is apparent that if this meticulous technique is combined with cholangiography, there would be fewer ducts explored and a greater accuracy in finding stones. However, if there is a clear cut indication for common duct exploration, such as jaundice, it should be done initially.

Summary

The experience with biliary tract operations at the Medical College Hospital of the Medical College of South Carolina during the first five and one half years of its operation are presented. In this series of cases, 226 operations were performed on 216 patients. There were four deaths which are briefly discussed. From this study, it is suggested that the morbidity and mortality in biliary tract disease may be further reduced by removal of calculous gallbladders prior to onset of complications, by more accurate evaluation of the common bile duct with routine operative cholangiography, and by planning cholecystostomy preoperatively in selected poor risk patients.

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SWELLING OF THE ARM AFTER RADICAL MASTECTOMY

TREATMENT BY INTERMITTENT COMPRESSION

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Swelling of the arm is a most distressing sequella of radical mastectomy for carcinoma of the breast. That in many cases it is a direct result of the operation and not a recurrence of the carcinoma was recognized by Halsted in 1921 in his classic paper on elephantiasis chirurgica.[1] He attributed the cause to a low grade streptococcal infection which blocked the lymphatics, manifesting itself at some time between a few days to some months after operation. The swelling is persistent and of a brawny nature, involving the upper arm, the forearm, and, at times, the hand. In 1937 Veal[2] demonstrated an obstruction of the axillary vein in a number of these cases and stated that in the early stages the swelling caused by venous obstruction is soft, pitting, and subsides upon rest with elevation of the arm, and that it progresses to the brawny type with the passage of time. Other authors have recognized as causative factors wound complications, skin flaps closed under tension, especially in the axillary region, and plastic flap closures. The increased use of post-operative intensive x-ray therapy apparently has been accompanied by an increased incidence of swelling of the arm.

The swelling may occur gradually or suddenly within a few weeks of operation or only after a period of months. The arm is heavy and painful and the patient may be more or less incapacitated. There occur commonly episodes of acute infection with increased swelling, pain and fever. The attacks subside with rest and antibiotics, but with each successive attack the arm is left in worse condition. In some cases, the axillary folds become involved.

There is no curative treatment, and until recently there has been no means of giving sustained relief. Bed rest with elevation of the arm is of value as a temporary measure and in acute attacks of infection, but is obviously impractical over a long period. Elastic bandages constrict upon bending the elbow, and also do not stay in place. Elastic sleeves have not proven effective in reducing the swelling.

A form of treatment which has met with success in controlling the swelling has been the application of compression to the arm. Several machines have been developed for

this purpose.[3, 4, 5] In the simplest type the arm is enclosed in a fabric sleeve in which is incorporated a rubber tube extending the length of the arm. Intermittent compression to the arm is obtained by inflating the tube at regular intervals. In the type [5] with which the author is familiar, the rubber tube is divided into about five compartments, in order that compression can be applied first to the hand, and then progressively upward toward the axilla, producing a reverse milking action. Pressure applied in this manner effectively reduces the swelling at a rate depending upon its degree and chronicity, as well as upon its cause.

At first, the treatment must be given for a period of several hours once or twice daily. Once the swelling has been reduced, the length of treatment can be reduced according to the needs of the individual case. When the swelling has reached a stationary level, the use of a snugly fitting, well-tailored elastic sleeve between treatments has been found of value in retarding the recurrence of the swelling and reducing the amount of compression treatment necessary.[3]

As in most cases it is necessary that the compression machine be used daily, or possibly every 2 or 3 days for an indefinite period of time, it is most desirable that the patient purchase one for use at home. She can take the treatment at her convenience while reading or even sleeping. The cost of a machine is $500.00 more or less, depending upon its type. This represents a large sum to some patients, but it must be weighed against the fact that it is the only way to obtain effective relief.

By controlling the swelling, the pain is relieved, the arm becomes useful, and is no longer subject to the frequent attacks of infection. In most instances, the patient is able to resume her normal activities.

Case 1: A white woman school teacher, 52 years of age had a right radical mastectomy with a split graft closure on August 1, 1960. The pathological report was carcinoma of the breast with axillary lymph node metastasis at level I. She was discharged from the hospital August 14, 1960 with primary healing of the incision and graft, and no swelling of the arm. She received, between August 29 and September 26, supervoltage x-ray treatment to the axillary, cervical and mediastinal nodes; total dosage 5000r. Swelling of the right upper arm was first noticed on October 5, 1960. The swelling gradually increased, extended to the forearm, and the arm became heavy and painful. On October 19th compression treatment was begun and given irregularly on an out patient basis. There occurred episodes of acute infection with increased swelling and pain. On May 3, 1960 she obtained a machine for use at home. She now uses it several hours every evening. On January 18, 1962 there was no evidence of recurrence of the carcinoma. The swelling persists to a moderate degree but is under control. She is free of pain and working regularly as a teacher.

Case 2: A white female registered nurse 57 years of age was admitted to the hospital one week following a simple mastectomy with a pathological diagnosis of carcinoma of the breast. The axillary lymph nodes were enlarged and firm. On November 24, 1961 she had a right radical mastectomy with a split graft closure. It was necessary to make a vertical incision in the medial flap in order to get a skin flap covering of the axillary region. Convalescence was prolonged by drainage from the axilla and a superficial infection of the donor site on the thigh. Supervoltage x-ray treatment, 5000r, was given to the right pectoral region from December 13, 1961 to January 12, 1962.

Swelling of the arm was first noted on December 26, 1961. The swelling increased and extended to the forearm. Compression treatment was started January 2, 1962. The response was satisfactory, however, the swelling recurred upon discontinuing the treatment on account of skin irritation caused by the sleeve. Treatment was resumed with good effect. She was so aware of the necessity of regular treat-

ment that she obtained a machine of her own. With regular daily treatments the swelling is kept under control. On February 2, 1962 there was no evidence of recurrence of the carcinoma.

Case 3: A normally developed overweight white woman was admitted three days following a biopsy diagnosis of carcinoma of the right breast. On June 29, 1959 she had a radical mastectomy with a split graft closure. The pathological report was carcinoma of the breast with axillary lymph node metastasis. She was discharged from the hospital two weeks after operation with the incision healing nicely. The graft was in good condition, and there was no swelling of the arm. She was given supervoltage x-ray treatment, total dosage 5500r, to the right supraclavicular and axillary regions from June 20 to August 18, 1959. Swelling of the arm was first noted on August 28, 1959, at which time a tumor was found in the left breast. On September 2, 1959 she had a left radical mastectomy. The pathological report was scirrhous carcinoma of the breast with no involvement of the axillary lymph nodes. She did not have x-ray treatment on the left side. On November 4, 1959 both operative fields were in good condition, there was no swelling of the left arm, however, there was considerable swelling of the right arm. The swelling persisted and there occurred episodes of acute infection. The swelling of the right arm became extreme and she was readmitted to the hospital August 19, 1960 for compression treatment. Response to the treatment was satisfactory and she obtained a machine for use at home. The swelling is under control and she has had no further attacks of infection. She takes the machine with her when she travels. On December 13, 1961 there was no evidence of recurrence of the carcinoma.

Case 4: A white housewife 31 years of age had a right radical mastectomy with a split graft closure on June 11, 1959. The pathological report was carcinoma of the breast with axillary lymph node metastasis. On June 23, 1959 she underwent a left simple mastectomy and a total hysterectomy with removal of the ovaries. Supervoltage x-ray treatment, a total dose of 6000r, was given to the right axilla, supraclavicular and mediastinal regions from July 5 through August 6, 1959. On August 5 there was noted slight swelling of the right upper arm. On September 8, 1959 she had radiation dermatitis which responded to tetracycline (Achromycin). Swelling of the arm was intermittent. On December 7, 1959 the arm swelling recurred, and from that time became persistent. Swelling and a bluish discoloration appeared in the hand. Compression treatment was instituted on an out-patient basis. The treatment was not regular and swelling and pain recurred during any lapse. On October 18, 1961 she acquired a machine for use at home. By regular daily treatment the swelling has been kept under control and she has had no more attacks of acute infection. For the past two months, she has been confined to bed for a nonrelated heart disease. Even under these conditions, it has been necessary to continue the compression treatment in order to control the swelling. On December 21, 1961 there was no evidence of recurrence of the carcinoma.

Summary

Swelling of the arm following radical mastectomy is not necessarily caused by a recurrence of the carcinoma, but may be the direct result of the operation. Causative factors are wound infection, venous obstruction, methods of closure, and x-ray treatment. There is no definitive treatment for relief of the swelling. Rhythmic compression by a machine designed for the purpose effectively controls the swelling. Patients more or less incapacitated by this distressing condition are made comfortable and rehabilitated.

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PATIENTS ARE PEOPLE

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People frequently are heard to say, and more often, probably, they think that doctors would be better physicians if they themselves had had a serious illness. What they mean to imply is that if a doctor has had to adapt himself to the discipline and the anxieties of illness, he would have a better understanding of the discomforts, the indignities, and the anxieties of their patients.

As Dr. Esther Lucile Brown states in the Russell Sage Foundation publication, *Newer Dimensions of Patient Care,* "Patients are people who are in trouble." Not only are they sick or afraid that they are sick, but they also have other troubles of various kinds. Illness or fear of illness causes anxieties. Even the prospects of a diagnostic check up, which may be more or less routine in character, may give rise to anxieties. The willingness to have such a study made inherently implies a fear that some unrecognized serious condition may be found. A wholly favorable report does not always reassure the patient whose anxiety was the basic reason for such a study.

The doctor, perhaps, more frequently than not is unaware of the nature or extent of the anxiety which brings the patient to him, and all too frequently he makes little effort to reveal it. Similarly often the patient hesitates to speak of it.

Again quoting Dr. Brown: "In recent years emphasis has been shifting in medical and other health professions from almost exclusive concentration upon diagnosis and treatment of disease to the diagnosis of persons in their totality." I cannot categorically deny the truth of that statement. To some extent, it is substantiated by what has become a cliche' by many doctors who say that they do not treat the disease. Instead, they treat the whole patient. That statement is heard so often, that it suggests that the idea of treating "persons in their totality" is drilled into students in medical school. If so, that fact would tend to confirm Dr. Brown's statement.

However, as she develops her thesis, it seems to me that she bases her discussion upon entirely different goals and techniques than those of doctors who rather proudly make the claim that they treat the whole patient rather than the disease.

To many doctors—and hospitalization insurance records and hospital charts will support the statement, I believe — treatment of the whole man too often implies hospitalization and a vast series of laboratory diagnostic studies. Some of these studies are rightly included in a diagnostic survey. Too many are done apparently as a part of a routine program without suggestive evidence of diagnostic indication.

Too frequently the significance of the laboratory findings is determined by the technical specialist who directed the tests, and too often he does so without benefit

of either a detailed or recorded comprehensive clinical history. The patient is told so often by his physician that the tests were negative, and he is reassured, and sent on his way.

However, the fact that patients are people who are in trouble does not necessarily mean that their troubles are caused by physical disease or by neurotic fear of such disease. Their troubles may be completely unrelated to functional or physical disease, even though they may give rise to symptoms suggestive of illness to them and even to the doctor.

The doctor who does not recognize the fact that his patient is a person in trouble and who after negative tests attempts to reassure him without seeking further for the nature and cause of the anxiety, has utterly failed to treat the patient in his totality. Instead of relief, the patient's troubles are frequently multiplied.

He has been subjected to tests, the purpose of which he does not understand, and whose significance is not explained to him. Clinically insignificant findings are mentioned frequently without full explanation of their harmlessness. As a result, the patient's anxieties are unrelieved, and frustration is added to them.

The patient who becomes seriously ill with little or no warning often is subject to a totally different type of anxiety, which may be far more distressing to him and a greater impediment to his recovery than those based on physical disorders. They might be labeled economic or familial. They have to do with economic security, job security, family security and comfort. Such an illness may cause not only loss of job, disruption of a business, loss of savings for education of children or for retirement, the loss of the home, or the car, or of appliances purchased on deferred payment plans, and a host of other disruptions and economic and family catastrophes.

The most common feature of the anxieties in this related group is that caused by the uncertainties of it all. How long will the disability last? When can work be resumed? Will I be physically able to do the same work that I did before I became ill? Those are questions which plague the patient and his family. They are questions which the doctor should recognize as cause for anxiety and should try to answer as completely and as honestly as he can. That is an essential part of the treatment of the whole man.

There are other anxieties which too frequently are not recognized by us doctors to whom hospital routine and discipline is so familiar, but which are so unfamiliar and often so frightening to the patient. Emotional adjustment and submission to hospital discipline is a necessary requirement of all patients.

Anxieties and frustrations caused by adjustment to hospital and therapeutic discipline may be and frequently are emotionally traumatic to the mature seriously ill patient. This is true particularly in seriously ill medical colleagues and in business executives. These are individuals who have been schooled to make important decisions, who have exercised independence of judgment and action, and who have been required to accept responsibilities. As a seriously sick individual subjected to the discipline of his doctor and of hospital routines, such a person is deprived of the symbols and prerogatives of executive status. All responsibility for making even quite personal decisions is denied him. The nature of his diet and the hour of his meals, items of privacy, selection of companionship are all decided for him. Dr. H. B. Richardson has remarked that in hospital patients even going to the toilet may be a privilege. The patient is made psychologically as dependent as a young child, and like a child, he is likely to become either objectively or subjectively rebellious.

To worsen the psychological reactions and to augment a tendency of rebellion, the orders which are designed to govern the patient's conduct and his medical regimen are made arbitrarily by the doctor. These matters frequently are not discussed

or explained to him. The value of such explanation and discussion is particularly true when dealing with a sick medical colleague. Since knowledge and pseudo-medical knowledge is now possessed by so many intelligent people, it is helpful in their management as well. In both the medical colleague and the intelligent layman, such explanation and discussion tends to boost their ego and to invite intelligent cooperation. It is much wiser to attempt to secure cooperation by explanation and by suggestive persuasion than by dogmatic edict.

To neglect to do so encourages rebellion and invites attempts at deviation from the ordered routine. Perhaps, more serious, may be deterioration of the patient's will to get well.

There are many things worse than death. Perhaps, loss of dignity and initiative by subservience to distasteful, poorly understood, and dogmatic discipline may come within that category.

This is the last of these reflections. Many of them, maybe most of them were caused by or suggested by my own recent period of hospital treatment. They are in no sense a criticism of my doctor, whom I like and admire very much. I am deeply grateful for his skillful and kindly attention; nor is it critical of the hospital, where I was shown every courtesy and kindness. They reflect my reactions to the therapeutic discipline, and the various non-medical anxieties which beset me. They were economic, family and business anxieties such as I have referred to: my retirement security program, effect upon partnership set up, a seriously ill brother in a distant city, and the uncertainties as to what extent I might be able to return to practice.

My experiences, reactions, and reflections, shall I believe, make me a better, a more kindly and understanding doctor than I was before. I shall be no wiser scientifically. My improvement will be in what we like to call the art of medical practice. I shall find time to try to make easier the transition by the patient from a person of independent judgment and action with adult prerogatives, to one with child-like dependence upon therapeutic and hospital routine. I shall try harder to preserve the dignity of my patient, recognizing that he is a person in trouble, and shall try to lessen his anxieties by encouraging him to discuss them with me. By so doing, I shall be treating him more nearly in his totality rather than treating his disease.

Muscle Relaxants in Black Widow Spider (Latrodectus Mactans) *Poisoning*—F. E. Russell. Amer J Med Sci—Vol. 243:159 (Feb.) 1962.

Nineteen patients were treated for black widow spider venom poisoning over a 3-year period. Antivenin was given to each patient 14 years of age or under. Adults were treated with calcium gluconate, or muscle relaxants, or both. Relief from the muscle pains and spasms was most marked following intravenous injection of methocarbamol. Mephenesin also provided adequate relief. The muscle relaxants had no effect on such findings as edema of the eyelids, ptosis, conjunctivitis, or pruritus. They appeared to relieve the patient's headache, nausea, and respiratory distress.

COMPARATIVE STUDY OF ANTICOAGULANTS FOR LONG-TERM USE— ACENOCOUMAROL vs WARFARIN

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The authors compare the effects of two anti-coagulants, warfarin and acenocoumarol, and find no essential difference in their efficacy.

The value of long-term anticoagulant therapy in cardiovascular disease has been well shown in numerous studies by many authorities. [1—5]

Several excellent articles have also appeared recently in which various anticoagulants were compared with one another, [6—7] but these have chiefly concerned short-term usage.

We wished to know whether one anticoagulant would be preferable to another for *long*-term usage.

When the present project was initiated in 1957, warfarin (Coumadin) had been shown over a period of several years to be a "nearly ideal" anticoagulant. [8-9]

A new drug, acenocoumarol (Sintrom), had just been introduced, with evidence suggesting that it might be a superior drug, particularly regarding "consistency" or "stability" of prothrombin times under long-term as well as short-term conditions. [10—11]

The older drug, warfarin, is 3-(alpha-acetonyl benzyl)-4-hydroxy coumarin. The newer drug, acenocoumarol, is 3-(alpha - acetonyl-4-nitrobenzyl)-4-hydroxy coumarin.

Material and Methods

This study, which extended over a period of nearly 4 years, included 56 patients with cardiovascular disease. Most of the patients had a myocardial infarction, but a few had cerebral thrombosis or thrombophlebitis. Short-term as well as long-term patients were included. All patients were treated with warfarin or acenocoumarol (2 patients were treated with each of the 2 drugs at different times.)

Of the 56 patients, there were 42 whose prothrombin records were available. These comprised 891 prothrombin determinations, involving 5155 patient-days. Three patients had short terms of therapy and were excluded. The records of the remaining 39 patients were subjected to statistical analysis regarding "consistency" of prothrombin levels.

Results

The statistician's report comprised two methods:

One method was to treat both groups as single samples from a large population of prothrombin times, without regard for the fact that the observations came from different patients. This was done by pooling the observations from each patient into one single sample for each drug. These observations were grouped into a frequency distribution which appears in table 1.

From the Heart Clinic and the Medical Service, Spartanburg General Hospital, Spartanburg, South Carolina.

TABLE I: THE POOLED PROTHROMBIN TIMES FOR WARFARIN AND ACENOCOUMAROL

Prothrombin Times In Seconds	Frequency For Warfarin	Frequency For Acenocoumarol
46-48	16	16
43-45	4	8
40-42	5	9
37-39	6	24
34-36	13	21
31-33	27	38
28-30	49	56
25-27	74	75
22-24	58	124
19-21	44	126
16-18	32	47
13-15	4	5
	332	549

SUMMARY OF DATA ABOVE

	Warfarin	Acenocoumarol
Mean in seconds	26.66	25.79
Standard deviation in seconds	7.35	7.26

The number of observations thus obtained from the 2 drugs was 549 for acenocoumarol and 332 for warfarin. These were treated as large samples, i.e., large sample statistical methods were applied. (In each case, that is, for each patient, the first day's observation was omitted since this was obtained before the drug was administered).

The mean for both drugs was computed and was 25.8 seconds for acenocoumarol and 26.7 seconds for warfarin. This difference was not significant; therefore the apparent difference of 0.9 seconds is not to be interpreted as saying that warfarin maintained a higher prothrombin time than did the drug acenocoumarol.

Since it was the experimenters desire to test the consistency of the 2 drugs, the measure of scatter about the mean for each drug used was the standard deviation. The standard deviations were 7.36 seconds for acenocoumarol and 7.35 seconds for warfarin. The difference of 0.01 was not found to be significant. The F Test for the significance of the difference of 0.01 second was used and 0.01 second was not significant.

Thus one can infer that there is really no difference in the scatter of the 2 drugs about their own means. From this, one may conclude that the drugs have about the same level of consistency when applied over a large number of observations.

TABLE 2. MEAN AND MEAN ABSOLUTE DEVIATION FOR EACH PATIENT IN SECOND METHOD OF COMPARISON

Acenocoumarol

Patient	N	Mean	Mean Absolute Deviation
Pa	22	26.6	6.0
Re	18	31.4	7.0
Sa	28	28.7	7.2
El	27	28.4	3.5
Ro	25	25.6	5.9
Ma	13	24.2	4.8
Jo	25	29.2	10.0
Bu	61	23.7	3.2
Cl	51	20.4	1.7
Sm	45	24.2	6.5
We	12	22.6	6.9
St	33	25.7	6.4
Se	13	20.0	3.5
Pe	14	22.2	1.5
Mi	21	33.2	8.5
Br	20	29.2	6.5
Bl	35	26.9	5.9
Mo	11	24.8	7.0
Ow	17	22.8	2.7

Warfarin

Patient	N	Mean	Mean Absolute Deviation
An	75	25.5	3.2
Zi	21	27.8	4.6
My	28	36.2	11.9
Ro	31	27.4	6.3
Ir	20	28.4	5.0
Gl	24	28.1	5.6
Jo	26	27.5	3.7
Cr	10	26.3	6.7
Di	34	26.9	4.0
Fe	22	28.7	4.5
He	23	24.3	2.2
Mu	31	29.5	9.9

SUMMARY OF STATISTICS COMPUTED FROM ABOVE DATA

Mean M.A.D.	(Seconds)	Number of Patients
Acenocoumarin	5.1	19
Warfarin	5.6	12

The second method of comparison was to treat each patient separately, and compare the averages of the mean absolute deviations for each drug. This was done by computing the mean absolute deviation for each patient, adding these for each drug separately, and dividing each sum

by the number of patients. For this purpose, any patient in the study who did not have at least 10 observations (that is, prothrombin times) was omitted, whereas each patient's observations were included in the pool sample used in the first method. (Since large deviations tend to be overemphasized by the standard deviations, the experimenters picked the mean absolute deviation as the best statistic to compare the scatter. The mean absolute deviation for each patient is given in table 2. The average mean absolute deviation was 5.1 seconds for acenocoumarol and 5.6 seconds for warfarin. This difference is *not* significant statistically.

Of the original 56 patients, there were 49 on whom data were available concerning the incidence of death and of hemorrhage. These are shown in table 3. It is noteworthy that the fatality rate for warfarin was less than half the rate than for acenocoumarol.

TABLE 3:

Anticoagulant	Patients	Hemorrhages	Percentages	Deaths	Percentages
Acenocoumarol	36	6	17%	8	22%
Warfarin	13	2	15%	1	8%

Comment

In this study, an "established" drug, warfarin, and a "newer" drug, acenocoumarol, were both found to be very satisfactory drugs for long term as well as short-term anticoagulant usage. However, it has been wisely pointed out that the physician would do well to continue to use established drugs with which he is familiar unless a "newer" drug can be shown to be superior.[7]

There is a need for further comparative studies of other anticoagulant drugs for long-term use.

Summary

In this comparative study of 2 anticoagulants for long-term use, a new drug, acenocoumarol, failed to show superiority over the older, established drug, warfarin.

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MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

DERMATOLOGICAL DON'TS

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Contact Dermatitis — Poison Ivy

White, Male, age 12

HISTORY

Forty-eight hours previously the patient had visited his grandparents in the country.

That evening he developed redness and itching on his legs, arms and face.

Within 24 hours the lesions became very pruritic with blister formation.

They had been treated with calamine lotion without relief.

PHYSICAL EXAMINATION

On lower legs were erythematous streaks studded with vesicles.

On the hands were groups of large bullous lesions and streaked vesicles.

On the face were areas of erythema with edema and closure of the eyelids.

The patient was asymptomatic except for pruritus and apprehension.

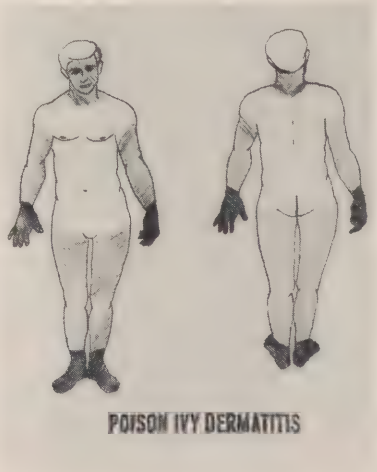
DIAGNOSIS
CONTACT DERMATITIS — Poison Ivy
TREATMENT DON'TS

1. Don't give vaccine therapy. This is not a treatment but "*only a preventive measure*".
2. Don't use greasy or emulsion type preparations on oozing surfaces.
3. Don't use "caine" preparations locally. They have a very high sensitizing index.
4. Don't use antihistamine creams or lotions. These are often combined with "caine" preparations. Sensitization is very high.
5. Don't get sunburned or use soap washings after the initial cleansing.
6. Don't use hot compresses; cool compresses can be used if the lesion are weeping or edematous.
7. Don't forget to have patients wash clothes, hair, garden tools, etc. to prevent further contact.

DO

1. Rupture bullae by sterile technique if they are large and uncomfortable.
2. Clean areas with a mild agent such as equeous Zephiran, 1/750 colorless.
3. Treat with local steroid cream with neomycin (1% hydrocortisone).
4. Advise patient that this is not contagious or auto-inoculable.
5. Prescribe systemic steroid therapy only in very extensive eruptions.
6. Consider desensitization if there has been an exquisite degree of sensitivity and repeated outbreaks, only then is it worthwhile.
7. Give oral alum precipitated extract if a desensitization procedure is to be done. They are unsatisfactory, but some degree of desensitization can be obtained.
8. Expect the majority of cases to be well in eight to ten days. If not, look for new contact or sensitization to "something" the patient is using as therapy.





Editorials

Annual Meeting Held

The 114th Annual Meeting of the South Carolina Medical Association was held in Myrtle Beach May 8, 9, 10, 1962 with a reasonably good attendance and a pleasing unanimity of opinion and action on the various measures brought up for consideration.

The chief actions taken were: 1. Complete opposition to the King-Anderson Bill, now in Committee, and complete endorsement of the Kerr-Mills Act now in successful operation in this state and many others. 2. The convention adopted a plan for re-registration of physicians, a proposal which brought out much controversy in the preceding session, but passed without any difficulty this year. Its intention is to permit a check on the movements and activities of physicians who are registered in South Carolina. 3. The Association also expressed disapproval of compulsory retirement of employed persons at the age 65 and recommended that efforts be made to continue employment for those who are capable of performing their jobs.

Election of officers proceeded without friction. Dr. Robert Wilson, long secretary of the Association was named president-elect and will follow Dr. J. H. Gressette at the end of his current term. Dr. Samuel E. Miller of Georgetown was named vice-president and Dr. Ben N. Miller of Columbia was elected secretary in place of Dr. Wilson. Dr. J. Howard Stokes of Florence was designated to continue his long, capable services as treasurer.

Dr. George D. Johnson of Spartanburg was re-elected delegate to the AMA and Dr. Charles N. Wyatt of Greenville was named alternate to the AMA. Three councilors were re-elected to a two year term viz. Dr. C. J. Scurry of Greenwood, Dr. William L. Perry of Chesterfield and Dr. John L. Flemming of Spartanburg. Members elected to the Mediation Committee were Dr. George McFadden of Newberry, Dr. Sam O. Cantey of Marion and Dr. Francis Owens of Union. To succeed Dr. O. B. Mayer, who requested that his name be withdrawn as a member of the Benevolence Fund Committee was Dr. Charles J. Lemmon, Jr. of Columbia.

Scientific and social events were well conducted, and the Association can look back on a well-arranged and well performed meeting. Myrtle Beach was selected as the place for the Annual Meeting of 1963.

Anti-Prophylaxis

It is nice to have one's opinions confirmed by authority. This writer has always belonged to the group which doubted seriously whether complications of respiratory illness were prevented by administration of miscellaneous antimicrobial drugs. Now an excellent and well documented article, backed up by the same quality of editorial, in the *New England Journal of Medicine* has shown that our impression seems to be right.

A very large group of children were included in the study reported, and the conclusion was reached that antimicrobial drugs administered prophylactically could not be shown to reduce the incidence of bacterial complication. If Oliver Wendell Holmes could feel some apprehension about the fishes in the sea which might be affected by dumping most of the then currently popular medicines into the ocean, we might now have some reason to wonder what has happened to all of the interiors and the biological balances of those uncounted children into whom unnecessary drugs have been poured in the hope of "preventing complications."

The New England J of M 266:683

F. B. I.

By an act of Congress, the week of May 13-19 was designated as Police Week and May 14 as Peace Officers Memorial Day. These events closely followed the observance of Law Day, U. S. A., on May 1.

Doctors often have an opportunity of recognizing criminals through various medical

peculiarities, and civic responsibility requires that they should give the F.B.I. all possible assistance in its effort to preserve our individual and collective safety.

Item

The following excerpt is from a letter received by an officer of the Home Owners Loan Corporation: "I want money as quick as you can send it. I have been in bed with the doctor for two weeks and he doesn't seem to be doing me much good. If things don't improve, I will have to send for another doctor."

Ed. Note: Any applicants?

ADDRESS OF THE PRESIDENT

Charles N. Wyatt, M. D.

Myrtle Beach, S. C., May 10, 1962

In the twenty-fifth chapter of Genesis, the twenty-seventh through the thirty-fourth verses are these words: "and the boys grew; and Esau was a cunning hunter, a man of the field; and Jacob was a plain man, dwelling in tents. And Isaac loved Esau, because he did eat of his venison; and Rebekah loved Jacob. And Jacob sod pottage; and Esau came from the field, and he was faint: And Esau said to Jacob, feed me, I pray thee, with that same red pottage; for I am faint; therefore was his name called Edom. And Jacob said, sell me this day thy birthright. And Esau said, Behold, I am at the point to die; and what profit shall this birthright do to me? And Jacob said, Swear to me this day; and he sware unto him; and he sold his birthright unto Jacob. Then Jacob gave Esau bread and pottage of lentiles; and he did eat and drink, and rose up, and went his way; thus Esau despised his birthright."

The Scriptures go on to tell us that after this Jacob became the leader instead of his elder brother as was the custom in Hebrew law. Jacob went on to gain considerable glory for himself and his family, while his brother Esau became separated from the tribe of Israel, founding a tribe of people that were afterwards destroyed by the Israelites.

To me, this is a parallel course in the healing arts today. Medicine in the early days, required the art of surgery from the barbers. As time passed, the surgeons became trained in medicine with special training in surgery. The doctor of the old school, did most of his surgery and, as surgical techniques increased, they began to have hospitals in which they cared for the patients. As time and techniques progressed, surgery became a many faceted art and specialities began to develop, the first being ophthalmology in 1917. Now there are some twenty or more specialty groups with many of these groups being broken down to lesser groups. Medicine has had a similar development. As the highly specialized groups have developed, so has the increase in the number of technicians. These technicians have and are becoming more technical and in some cases it puzzles the patient to know who is doing what to whom.

Another specialty group of medicine developed also. This was the Government Public Health Service. This was organized in July 1798. The purpose of this organization, as originally stated, was to operate Marine Hospitals for the care of Merchant Seaman. Subsequent legislation has vastly broadened the scope of activities. Reorganization Plan I of 1939 transferred the Public Health Service from the Department of the Treasury to the Federal Security Agency. By Reorganization Plan I of 1953, the Federal Security Agency in April of 1953 became the Department of Health, Education and Welfare. Major functions of the Service are: (1) To conduct and support research and training in the medical and related sciences and in public health methods and administration; (2) To provide medical and hospital services to persons authorized to receive care from the Service, to aid in the development of the nation's hospital and related facilities, and to prevent the introduction of communicable disease into the United States and its possessions; (3) To assist the states and other governments in the application of new knowledge for the prevention and control of disease, the maintenance of a healthful environment, and the development of community health services.

As the country grew, the doctors grew with it but not in the same proportions. Doctors participated in the government and politics at the local, state and national level. They were vitally interested in community developments and many served on school boards. They were leaders, well trained in a community, and their services were often sought, and occasionally drafted, because they were very intimately known in their areas.

Time marched on and great advances were made in research and many apparatuses were developed to help in the diagnosis of many conditions, one of the outstanding being the cardiograph. As these things developed, more technicians were trained. Hospitals became more a place for treating and curing people than for sending them there to die. Insurance, of all kinds, began to expand and in the 1940's, the Blue Plans came into existence. Going to hospitals became popular, instead of tragic, and this involved more and more technicians, more and more labs, larger and more hospitals. And with hospital expansion, it became necessary to employ trained technicians to manage these and with the hospital expansion, it became necessary to get lay people and

foundations interested in them to the extent that Boards of Trustees or Governors were appointed or elected to control. Soon the hospital became ever a bigger enterprise, money was constantly needed and sought after, but it was never quite enough. So, the Government stepped in and the Hill-Burton law became the instrument for further hospital building.

And with the ever expanding hospital facilities, there was an ever increasing number of people needed to care for the sick. Nurses were trained and became executives, managing wards and floors — practical nurses were trained to help. Practical nurses became trained nurses. They were insufficient, so came the aids. Now it is claimed that it takes about 3½ persons to care for each patient.

So much for allied medical help — for while this was taking place, the staff of the hospital has had to keep apace. Membership on staffs has become more rigid. The staffs have been organized and reorganized until the requirements have been raised so that the specialists do most of the treatments within the hospital. The requirements of staff privileges have been increased both in training and experience; there are specified obligations imposed on the entire membership of the staff in that they now not only have to take services and attend clinics, but they are required to attend section meetings weekly and general staff meetings at least 75% of the time. In those institutions that are accredited for training of interns, they are supposed to teach the interns. These requirements are made mandatory by a governing board and the Committee on Accreditation of Hospitals of the AMA.

During all this time, an increase of hospital rates is taking place. Also with increase in research, hospital beds, hospital insurance, and more and better specialization, people are living longer. The span of life increases up to the Bibilical three score years and ten. Births increase, people live longer and population and inflation increase. Then suddenly the politicians begin to see a source of increasing voting strength in the "Senior Citizen" and they rapidly conclude that the people should be taken care of in their days of retirement, so various and sundry plans are invented to do this. The lines are formed and the debates, battle, and schemes are begun in the Congress until it is finally decided by these schemers that Social Security is the way. Increase the tax on employee and employer, have the present and future generations for years carry the load for these 17 million "Senior Citizens." Politicians decide there are not enough doctors, dentists, nurses, Public Health personnel, so legislation is introduced to furnish scholarships, build more medical schools.

What is going to be our answer to these intrusions upon our freedoms? It is claimed that we do not have enough medical schools, that we cannot produce enough trained medical personnel to take care of the explosive population increase in the immediate years to follow. It is also claimed that we are getting too highly specialized. Perhaps this is true, but so is this true of the Church according to an article in the *Dialog, a Journal of Theology*, written by Loren E. Halvorsen, who states, "Innumerable meetings, immersions in 'Churchiness', that not a minute to spare, crowding of the Temple Calendar, and the pursuit of statistical success have left many of the most active members exhausted both in body and spirit . . . They responded to the calls for thrill in the organizational church with great expectation. They entered what they supposed to be the sanctuary with a sense of awe. But the routine churchly duties have produced a different kind of wonder." Halvorsen goes on to say that by this increased activation of the church, many of the members have lost sight of the main purpose of the church and are hiding from God. It seems that a decrease of spiritual vitality usually occurs when the church is enjoying its greatest prosperity. Doesn't this somewhat resemble our profession? During and shortly after World War II, wasn't there a demand and a great urge for doctors to limit their work? Collections were good and service in the Armed Forces brought about a desire to work less hours, have week-ends off, and to go on vacations at will.

Often, too often, those of us that served in the Armed Forces retained this habit of remembering patients by their disease, rather than by name. The sole interest became the desire to get them back to duty. Laboratory and x-ray work was easily obtained and very often it was necessary to throw the book at these service men in order to expedite their return to duty. The doctor-patient relationship suffered a very severe set-back during the war years and immediately after. Has it ever been freely restored? Why is it that we hear so much about the short time doctors spend with patients. Why is it we take so little time to talk to the patient. Why is it that the tranquilizers head the list of prescriptioned drugs? Mostly, my friends, because of the facts of time, time to explain to the patient his trouble, time to talk, time to understand one another.

In a recent article published in one of the economic journals, it was brought out by the author that group practice, where there are 15, 25 or more doctors in a group covering most or all of the various specialties, was the best type of practice today. These authors emphasized that the doctors' time must be preserved and that he could not listen to the many complaints of the patient, and that paramedical personnel should be used to do a lot of the spade work that the doctor used to do. It emphasized the fact that the doctor is more a scientist and that the patient is older, more educated and more demanding on specialized skills. The author further listed several factors that are acknowledged as attributes of good medical care — they are the ready access to a broad field of specialized skills and diagnostic aids such as are assembled in a group. The availability of care and information which is usually present in a group is valuable, because most patients and their families do not retain the same doctor for long, but where the patient is treated in an institution, records are kept and on each referral of the patient, a complete record is made. It further states that money has always been a barrier to good

doctor-patient relationship and that charges, payments, billings, cost of medication, do not help to establish mutual confidence, therefore, the insurance approach is the best method of improving the doctor-patient relationship and of guaranteeing good medical care. And again it is stressed that the patient may "feel that the precious moments the doctor gives him are wholly his." Again the advantages of an institutional setting with a group and broad insurance coverage is stressed. The financial burden inflicted on the family by illness often plays a part in the response to the treatment given. The doctor should not ignore these, but should have "skilled hands in his organization to handle this." The article stresses also that in a group practice the freedom of choice is greater, less expensive, and treatment is of high quality and proper, working within an institution. And the Health Insurance Plan of Greater New York was openly and graciously praised. The article concluded with the following: "Similarly, in the field of medical care, scientific, technological, and economic progress have made it almost inevitable, that effective doctor-patient relationship will have to be based on institutional arrangements." Will it?

And so, in conclusion, have we, in our zeal to be ever, ever better scientists, forgotten how to show interest in the patient and his family? Have we forgotten the ART of medicine so much so that the human being has turned into a diseased organ or organs? Have we, as quoted from the *Journal of Theology,* become so highly specialized that we are forgetting the patient as being human and overlooking the subject? Have we forgotten that patients think, eat, feel, see, hear, the same as we? Are we, as doctors, pricing ourselves out of the field by patronizing high priced hospital and office procedures, rather than talking and examining the patient? Have we, in our desire for material things and goods, ceased to have charity in our hearts, and have begun to look to BIG GOVERNMENT for payment of our medical indigent and "Senior Citizens?" Have we, as Esau, despised our BIRTHRIGHT to such an extent that we have accepted third party entry into the practice of Medicine?

May the good Lord forbid that the practice of medicine should ever be practiced for money alone. If we ever have to be Esaus, and exchange our birthright, let it be for more knowledge to benefit our patients, more humbleness in the presence of our clients, and more fight in the preservation of our freedom to practice medicine to the best of our ability without interference from any Government or organization, or third party.

May we, as medical men re-evaluate ourselves, in that once again we may recapture the image that we had and enjoyed some years back. May we, as doctors, assume our proper roles as citizens of the community, interesting ourselves in those things that involve the lives and livelihood of our neighbors, and in the politics that to a more large extent, are exerting more and more pressure on those lives. May it never be said that the medical profession of America sold their birthright, as Esau, for a mess of pottage.

Minutes of Council Meeting
Columbia, S. C.
February 7, 1962

A special meeting of Council was held at the Columbia Hotel on February 7, 1962. The meeting was called to order at 3 p. m. by the Chairman, Dr. John Brewer. Members present included Drs. Wyatt, Stokes, Evatt, Scurry, Perry, Cain, Eaddy, Booker, Waring, Wilson, Thomas, Gressettee and Mr. M. L. Meadors.

The minutes of the special meeting of October 18, 1961 were not read, but were held over for a subsequent meeting.

The Chairman announced that one of the purposes of this meeting was to consider a new proposition offered by Tobias and Company, Professional Public Relations Consultants for the Association. Dr. J. I. Waring, Public Relations officer of the Association, introduced Mr. T. J. Tobias who spoke of the activities of his firm in the Public Relations Programs for several years past. He noted the part his firm had in the presentation of the TV Programs (House Call), in the organization of the Speakers' Bureau, and said that the present program dealt with pending political activities. Mr. Tobias presented tape recordings of two radio speeches by representatives of the Association, and noted that the costs incurred by his firm were such that a new financial arrangement must be made if they were to continue in this capacity.

Dr. J. I. Waring made some comments, after which a general discussion ensued in which all members of Council participated. Dr. Brewer noted that true public relations starts in the sick room and that nothing can alter this fact. Dr. J. P. Cain commented on the fact that the consulting firm was simply in a position where they could help in the gathering of material and preparing it for presentation, but that each Councilor had to become active for public relations programs at the county level and in the end its success depended on the doctor in the various communities. After this Dr. Booker moved to accept the offer of Tobias and Company at a fee of $300.00 per month plus expenses, effective January 1st through May 1st, for five months only, until the House of Delegates had decided whether the program should be continued. This motion was passed, with Dr. Eaddy asking to be recorded as in opposition.

Dr. J. P. Cain, Chairman of the Insurance Committee announced that the Columbia Casualty Com-

pany had cancelled their group plan of accident insurance, and presented five alternate plans for the Association in its stead. The Insurance Committee recommended the acceptance of a policy offered by the Globe Indemnity Company, and this was approved by Council.

Dr. Frank Owens then presented his report from the Special Committee appointed to study the salary structure of employees of the Association. Council went into Executive Session for the presentation and discussion of this report. After resumption of regular session a motion was made to change the annual salary of the Executive Director to $12,000 a year, with the privilege of continuing his law practice as at the present time. This motion was passed, with Dr. Eaddy requesting that it be noted that he had abstained from voting.

It was further moved that the travel allowance be increased from 7¢ a mile to 10¢ a mile for all those now entitled to such an allowance, and the motion to the effect was carried. Council affirmed the recommendation of the Committee that the Secretary of the Association should receive mileage when attending official meetings, but disapproved a per diem allowance. Council further affirmed the recommendation that the secretary to the Secretary be paid at a rate not to exceed $50.00 per month.

Dr. Owens spoke of the possibility of a "Good Samaritan" law in South Carolina, noting the California law, but no action was taken by Council and it was referred back to his committee for further study. Dr. Owens further reported as Chairman of the Committee on Selective Service, that several physicians from South Carolina had been called and that more would expect future induction into military service.

It was noted that the bill to require the labeling of blood for transfusion by race had passed in the House, and the hope was expressed that it might be possible to block its passage in the State Senate.

A report was made that professional service incorporation bills had been introduced in the Legislature, but no action was taken by Council at this time. The report of this committee was approved, and the Executive Secretary was instructed to send information regarding the present state of professional service incorporation bills to all members of the Association.

Dr. Charles Wyatt reported that the Liberty Life Insurance Company was undertaking a radio program for educational purposes and it was suggested that the Public Relations Committee be asked to report at the next meeting of Council as to the advisability of joint activity with this insurance company and any other interested groups, provided that such action was approved by the House of Delegates.

The Executive Secretary reported to Council that several pharmaceutical firms had offered to pay a donation to the Treasury of the Association and not to present an exhibit; however, it was the opinion of Council that exhibitors be billed only for space used at Association meetings, and that no donations be accepted under any circumstances.

There was no further business at this time and the meeting adjourned at 6:15 p. m.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

News

AMPAC

Sen. John G. Tower of Texas, and Rep. Harold B. McSween of Louisiana will be two of the top speakers at the $25-a-plate banquet given by the American Medical Political Action Committee Sunday, June 24th, at 7 p. m. in the Grand Ballroom of Chicago's Palmer House.

Physicians and their wives, as well as others interested in political education and action by the medical profession, were urged by Dr. Gunnar Gundersen, AMPAC's chairman, to attend the banquet and participate in other activities scheduled for the day. Doctor Gundersen said more than 750 persons were expected to join Sen. Tower and Rep. McSween at dinner, reservations for which are now being made through AMPAC, 520 N. Michigan Ave., Chicago 11, Ill.

"Many physicians and their wives who had planned to arrive Monday for the AMA's 111th Annual Meeting have now re-arranged their schedules to arrive Saturday or Sunday," Doctor Gundersen said. "The profession is fast awakening to the need for effective, concerted political action. This is evidenced by the snowballing support being given state political action committees and AMPAC itself.

"The program scheduled in Chicago is arousing unusual interest, and we believe that those who take part in the activities scheduled will find their time well spent."

After a closed breakfast meeting of AMPAC's National Advisory Committee, at which a representative of every state will be present, a working session on political education and action—from 9:30 a. m. until noon — will be opened to physicians, their wives, and others. Nationally prominent speakers will address the group on subjects of immediate political importance.

Dinner will conclude the day's program.

Sen. Tower is the first Republican to be elected to the Senate from Texas since Reconstruction, and the only Republican Senator ever elected by popular vote from any of the former Confederate states. He is the

only Senator to serve on the influential Senate Republican Policy Committee during his first term, and also functions as a member of the Republican Senatorial Campaign Committee.

Sen. Tower fills the seat vacated by Lyndon Johnson, now Vice President. A former professor of political science, Sen. Tower is assigned to two major Senate Committees — Banking and Currency, and Labor and Public Welfare.

Rep. McSween was elected to the 86th and 87th Congresses from the Eighth District of Louisiana. A Democrat, he practiced law prior to entering public life. He is a member of the House Committee on Agriculture.

Obstetric-Pediatric Seminar

The Annual Post Graduate Obstetric-Pediatric Seminar sponsored by the Maternal and Child Health Divisions of the State Health Departments and the Maternal Health Committees of the State Medical Associations of Georgia, Florida, Alabama, Mississippi and South Carolina will be held August 16-18 with headquarters at Colonial Inn, St. Petersburg Beach, Fla.

Speakers will be: Richard W. Blumberg, M. D., Emory University School of Medicine; Margaret Q. Jenkins, M. D., Medical College of South Carolina; Michael Newton, M. D., University of Mississippi Medical Center; Roy T. Parker, M. D., Duke University Medical Center; and Peter A. Steward, Ph. D., Emory University.

The Seminar is approved by the American Academy of General Practice for 12 hours Category I. Reservations should be made as early as possible.

Duke Post Graduate Medical Course

For the fourth consecutive year Duke University Medical Center offers a Post Graduate Medical Course to be held at the Morehead-Biltmore Hotel, Morehead City, N. C. July 16-21. Designed to appeal to physicians and their familes the daily programs begin at 8:30 a. m. and end at 1:30 p. m. in order that the afternoons will be free for recreational activities.

The program is approved for 30 hours, Category I, Post Graduate Education, required by the A.A.G.P. The course is limited to 100 participants and registration should be made as soon as possible.

Care of Premature Infants

Under the auspices of the U. S. Children's Bureau and the New York State Department of Health, the Institutes for Physicians and Nurses in the Care of Premature Infants at New York Hospital—Cornell Medical Center, New York City, will be repeated during the fiscal year, 1962-63.

The number of sessions for the 1962-63 fiscal year is contingent upon the need for them as expressed through the number of applications received. Those institutes which are definitely scheduled will start on the following dates: September 17, 1962; November 5, 1962; Janaury 7, 1963; March 18, 1963; May 13, 1963.

Because of the many administrative details involved in processing the applications, it is desirable that applications reach New York Hospital at least two months before the date of the Institute for which the candidates are applying.

Further information may be had from Dr. Hilla Sheriff, State Board of Health.



"Tough skin, eh Doctor?"

Coastal Medical Society

The regular meeting of the Coastal Medical Society was held at the Edisto Grill, Jacksonboro, S. C. on Thursday, April 19, 1962. Guest speaker was Dr. H. R. Pratt-Thomas of Charleston, S. C.

S. C. Tuberculosis Association

Dr. Edward F. Parker of Charleston was re-elected president of the S. C. Tuberculosis Association at the group's 45th annual meeting in Greenville.

The Charleston County Tuberculosis Association was singled out as one of nine counties for outstanding achievements in the 1961 Christmas Seal campaign. The Dorchester Association also received an award for the drive.

Dr. Heins Named by Symphony

Dr. Henry C. Heins, Jr. was elected president of the Greater Charleston Symphony Orchestra Association at the Association's annual meeting held April 24.

Pulmonary Symposium

The Eleventh Annual Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases will be held in Saranac Lake, N. Y., July 9-13. Sessions will be held in Hotel Saranac and various sanatoria and laboratories in the Saranac Lake area and physicians desiring to make patient rounds will have that opportunity. The symposium is acceptable for 27 hours of category 1 credit by the American Academy of General Practice and the College of General Practice of Canada.

A program of scenic tours has also been planned for families should they wish to join with the other physicians' families in visiting the area.

Those interested should write: Registrar, Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases, P. O. Box 627, Saranac Lake, N. Y.

Maternal and Child Health Fellowships

The Children's Bureau is again making fellowship funds available to qualified students for graduate work in the field of Maternal and Child Health. These fellowships, open to physicians, nurses, nutritionists and social workers, cover all tuition fee and provide a tax-free stipend for periods up to eleven months. Those interested should write: The School of Public Health, The University of Michigan, Ann Arbor, Michigan.

Blue Cross and Blue Shield Elect William Sandow

William Sandow, Jr., Executive Director of the S. C. Blue Cross and Blue Shield, has been elected Treasurer of the National Association of Blue Shield plans. The election took place April 1 at the Annual Meeting of Plans held at Colorado Springs, Colorado.

Dr. Able Resumes Practice

Dr. Legrand G. Able has returned to his surgical practice at 751 N. Church St., Spartanburg, after a recent accidental injury. His practice is limited to surgery and gynecology.

New Associate

Dr. Henry E. Plenge and Dr. Rupert E. Hodges announce the association of Dr. Henry S. Anderson in the practice of radiology. Their offices are at 157 Catawba St., Spartanburg.

Pelion Area Gets Physician

Through the efforts of the Pelion Community Club and Jack Stone, secretary, particularly, the services of Dr. Robert N. McCallum have been secured on a part-time basis for the Pelion area. The doctor, a native of Indiana, is stationed at Fort Jackson, and has secured permission to hold office hours at Pelion on Monday, Wednesday and Thursday from 5:00 until 8:30 p. m .

Brochure on Headaches

"Headache — Hope Through Research", a brochure prepared by the National Institute of Neurological Diseases and Blindness and published by the U. S. Department of Health, Education and Welfare, has been recently made available by the Public Health Service. Listed as Public Health Service Publication No. 905 and Health Information Series No. 104, it explains some of the causes and types of headache and reviews the latest treatments known to medical science. Single copies may be obtained from the Public Health Service; orders under 100 are 10¢ a copy, orders over 100, 7.5¢ a copy, from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

American Geriatrics Society

The 19th annual meeting of the American Geriatrics Society will be held June 18-20 in Chicago, with headquarters in the Palmer House.

Major areas for discussion will include geriatric medicine and surgery, and geriatric socioeconomics. All physicians are invited to attend and there is no charge for registration. Further information may be obtained from Mr. Henry Blanchard, Executive Director, American Geriatrics Society, 10 Columbus Circle, New York, 19, N. Y.

Course on Isotopes

Dr. W. A. Klauber, Self Memorial Hospital radiologist, taught a course on Radioactive Isotopes in March at Emory University Medical School in Atlanta.

The course leads to the licensing of physicians in the use of radioactive isotopes from the Atomic Energy Commission. The full course lasts two weeks. Dr. Klauber was on the program for three days.

Radioactive isotopes from the AEC have been used in Self Memorial Hospital for about two years under Dr. Klauber's supervision.

Burn Is Named President By South Carolina Psychiatrists

Dr. Edward M. Burn, director, psychiatric Residency Training Program, S. C. State Hospital, has been elevated to the presidency of the S. C. District Branch, American Psychiatric Association. His term begins in the fall.

The group met recently at the Jefferson Hotel.

Presiding at the meeting was the president, Dr. W. P. Beckman, S. C. state director of mental health, Columbia.

Other officers named were Dr. Joseph J. Marshall, Department of Psychiatry, Medical College of South Carolina, Charleston, president-elect; Dr. Lawson H. Bowling, medical director, Columbia unit, State Hospital, secretary-treasurer, and Dr. Sol B. McLendon, medical director, State Park Unit, State Hospital, councilor.

Doctor Hall was elected a delegate to represent the state district branch at the Assembly of District Branches at the APA convention in Toronto, Canada, May 6-11. The alternate is Dr. J. J. Cleckley, professor of psychiatry, Medical College of South Carolina, Charleston.

Dr. Ben Miller Elected

Ben Miller, M. D., of Columbia, has been elected as a delegate to the annual meeting of the American Society of Internal Medicine in Philadelphia.

Clinic Expands At Darlington

Dr. John Wilson, owner of the Wilson Clinic in Darlington, has announced that there will be an addition of a new wing to increase its capacity to 27 beds in the near future.

This will mark the second major extension of the clinic, since it was erected in 1958. The new wing will provide patient rooms for an additional eight beds and will also have an emergency room.

A new X-ray machine has also been installed in the clinic.

Hollings Picks Local Doctor For Atom Unit

Gov. Ernest F. Hollings has named an Orangeburg physician to represent the state's medical profession on the Committee for Peaceful Uses of Atomic Energy.

Dr. J. Harvey Atwell Jr. of Orangeburg will serve with Arthur Williams of Columbia, Fred Burns of Laurens, John Welch, Jr. of Charleston and John Trask of Beaufort.

Legislature Passes V. D. Bills

In March and April of this year the South Carolina Legislature passed two bills concerning venereal disease.

Bill No. H 2297 states that "any laboratory performing a positive laboratory test for venereal disease shall make a report of such case or positive laboratory test for venereal disease to the State Board of Health in such form and manner as the State Board of Health shall direct, and shall cooperate with the State Board of Health and local boards of health in preventing the spread of venereal diseases."

Bill No. H 2298 amends Section 32-593, Code of Laws of South Carolina, 1952, relating to reports of cases of venereal disease, so as to *delete* a provision which prohibits the divulgence of the names of persons so afflicted. The amended bill reads: "Any physician or other person who makes a diagnosis of or treats a case of venereal disease and any superintendent or manager of a hospital, dispensary or charitable or penal institution in which there is a case of venereal disease shall make a report of such case to the health authorities according to such form and manner as the State Board of Health shall direct."

BLUE CROSS . . . BLUE SHIELD

NATIONAL BLUE SHIELD SENIOR CITIZEN PROGRAM

The National Blue Shield Program for Senior Citizens as proposed includes the following provisions:

Benefits

1. *Surgery,* wherever performed, including all operative or cutting procedures, the treatment of fractures or dislocations, and related pre-operative and post-operative care.
2. *Anesthesia,* when rendered by a physician, other than the attending surgeon or his assistant, and who customarily bills for his services.
3. *In-Hospital Medical Care* will be provided on the basis of 70 days per admission, except in cases of pulmonary tuberculosis or nervous and mental disorders for which this benefit is limited to 30 days in any consecutive 12-month period. In-hospital medical benefit days, except those for pulmonary tuberculosis and nervous or mental conditions, are fully renewable after 90 days elapse between discharge from a hospital or nursing home and readmission to a hospital. Successive periods of hospitalization for purposes of determining in-hospital medical benefits will be considered as one confinement unless 90 days elapse between the date of discharge and the date of re-admission.

   a. *Intensive Medical Care*—In-hospital medical services rendered by the attending physician to a subscriber who is eligible for in-hospital medical care benefits, and who is confined with a condition of an unusually serious nature which requires additional time and study over and above usual in-hospital medical care.

   A history and physical examination alone do not constitute intensive medical care. In order to define the unusual nature of such services, the attending physician will be required to state clearly the nature of the patient's condition and

the circumstances necessitating intensive medical care, and to give a brief summary of the services provided and time involved.

Benefits for intensive medical care are payable in lieu of other benefits available during the same day of hospital confinement, and are payable only for those days during which the patient's condition necessitates intensive medical care.

b. *Concurrent Medical Care*—Coverage will be provided for required medical care not related to surgery, not constituting a part of the usual, necessary and related pre-operative or post-operative care, and requiring supplemental skills not possessed by the attending physician or surgeon.

4. *Nursing Home Care* will be provided when a subscriber is confined to a nursing home within 24 hours following discharge from a hospital for continued care. Benefits will be provided for visits of a physician on the basis of one visit per week for a period of 13 weeks. Nursing home visits are *in addition to* the total of 70 days in-hospital medical care provided. Visits in a nursing home for nervous or mental disorders or pulmonary tuberculosis are not covered.
5. *Radiation Therapy,* including the use of x-ray or radioactive isotopes in the treatment of disease by a physician is provided wherever this service is rendered.
6. *Diagnostic X-Ray* will be provided only when the service is performed by a physician who customarily bills for his service.
   a. X-ray examinations are provided when ordered by an attending physician for a hospitalized subscriber when such examination is consistent with the condition for which the subscriber has been admitted to a hospital.
   b. X-ray examinations performed in a physician's office or in the out-patient department of a hospital when such an examination is required as the direct result of an accident and within 72 hours of the accident.
7. *Laboratory and Pathological Service* includes laboratory and pathological examinations when ordered by the attending physician for a registered bed patient in a hospital and when such examinations are consistent with the condition for which the subscriber was hospitalized, and when performed by a physician who customarily bills for his services.
8. No physical examinations will be required for enrollment under this program and all pre-existing conditions, whatever their nature, will be covered after a six-month waiting period.

SERVICES NOT COVERED

Cosmetic surgery, unless necessary to correct conditions resulting from accidental injuries.

Dental Services or Procedures involving the teeth (whether impacted or not) or the structure directly supporting the teeth.

Electroshock or Insulin Shock Therapy.

Physical Examinations and Immunization Injections.

Treatment, Care or Services for any condition incidental to or resulting from pregnancy.

Medical Service in a hospital rendered to a subscriber who is hospitalized on the effective date of his coverage and who remains continuously confined therein.

Anesthesia Service when rendered for a service not covered in the contract.

In addition, this contract contains the usual and customary general exclusions such as care provided by the Veterans Administration, or care rendered in connection with any condition arising as a result of or in connection with employment or care received by virtue of any law of the United States or any state or political subdivision thereof, etc.

The services covered under the National Blue Shield Senior Citizen Program will be provided on a paid-in-full basis for single persons whose income is $2,500 a year or less, and for a husband and wife whose combined annual income is $4,000 a year or less.

The term "income" for purposes of this program is defined as "the gross annual income from all sources." Income of members will be certified at the time of their enrollment.

For subscribers whose incomes exceed those established for paid-in-full benefits, the physician may make a charge in addition to the Blue Shield payment he receives.

Deaths

DR. MILTON WEINBERG

Dr. Milton Weinberg, 76, died suddenly at his home in Sumter, February 21.

Born in Manning, Dr. Weinberg was a graduate of the University of South Carolina and John Hopkins University. He served in World War I as first lieutenant in the Medical Corps. Dr. Weinberg was retired.

DR. HANNIBAL L. BAKER

Dr. Hannibal Legette Baker, 91, of Hemingway, died in the Folk Nursing Home of Florence April 24 following a long illness.

Dr. Baker was born October 28, 1870 at Centenary in Marion County. He received his education from Wofford College and was graduated from Baltimore Medical College in the class of 1892. He practiced medicine in Lake City and the Union Community near here before he established his permanent home in Hemingway in 1906.

He was a founder of Hemingway and was active in

religious, civic, and educational activities of his community.

Dr. Baker was instrumental in organizing and building the First Methodist Church here. He served as a trustee for 38 years. He was one of the first trustees of the Hemingway school system. He was a past master of the Indiantown Masonic Lodge, Hemingway where he had been awarded a 50-year pin and made an honorary member for life. He was a member of the American Medical Association, the Southern Medical Association, the Pee Dee Medical Association, and the Williamsburg Medical Association. He had served as a Seaboard Air Line Railroad surgeon for 31 years.

During World Wars I and II, Dr. Baker received a certificate of recognition from President Woodrow Wilson, Franklin D. Roosevelt, and Harry S. Truman for services rendered his country.

Dr. Baker was voted "Man Of The Year" in Hemingway in 1952.

DR. W. S. HARVIN

Dr. Winfield Scott Harvin, 72, died at noon April 21 at the Clarendon Memorial Hospital in Manning. He had been ill since November.

Born in Manning in 1889, Dr. Harvin was educated in the Manning schools, Clemson College and was graduated at the Medical Colloge of South Carolina in 1912.

For five years he practiced at Hendersonville and Dubarton and came to Manning in 1917 where he continued practicing until his illness. He was a past grand master of St. Peters Lodge No. 54, AFMA, Shriner, a charter member and past president several terms of the Manning Rotary Club, and a director at the time of his death.

He was past president of the Sumter - Clarendon Medical Society, and the Seventh District Medical Society and served as chief of staff of the local hospital.

Civil Defense



Space flight medical problems and planning for major disasters were topics of the last in a current series of television programs televised through the facilities of the Educational Television Center (Columbia). A ninety-minute program, televised May 3-4, closed out the series of special programs prepared especially for South Carolina doctors and allied medical personnel. Appearing on a panel which discussed disaster medical problems and planning were (left-right) Dr. Dale Groom, Department of Medicine of the Medical College of Charleston (program moderator); Dr. Carruth J. Wagner, Chief of the Division of Health Mobilization, Department of Health, Education and Welfare, Washington, D. C.; Col. Thomas Nelson of the Brooks Army Medical Center, Ft. Sam Houston, San Antonio, Texas; and Dr. Robert J. Solomon, Civil Defense Director of Berkeley County.

Public Relations

NOW HEAR THIS!!

CALLING ALL SOUTH CAROLINA DOCTORS...

In the Fight Against the King-Anderson Bill



EDITORIAL SUPPORT

South Carolina newspapers continue to support physicians in their efforts to put the true facts of the King-Anderson Bill before the public. The following editorial appeared recently in the Charleston *News & Courier*. It is typical of the excellent editorial support which the medical profession has received throughout the state.

"A Failure in Britain"

Socialized medicine is bad for the public as well as for the medical profession. A look at Britain's unfortunate experiment with its National Service ought to convince Americans that they should not repeat the mistake on this side of the Atlantic.

After 14 years of socialized medicine, Britain has an acute doctor crisis. Nearly one in three British medical school graduates leaves the country each year.

British hospitals now rely heavily on foreign doctors, mostly from Asian countries where standards of medical training are low. Without these doctors — chiefly from India and Pakistan — medical service for Britons would break down completely.

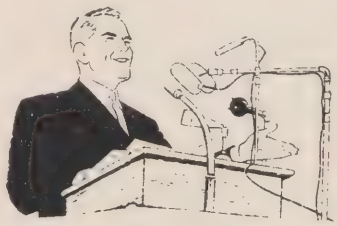
Family doctors in Great Britain are overworked and disillusioned. An article in *U. S. News & World Report* says that patients may get only two or three minutes with a doctor, who sometimes must see 60 to 80 people a day. Average income of a family doctor is about $6,700 a year.

Because opportunities are better elsewhere in the world, able physicians are going where the grass is greener.

While public service is a motive, financial incentive is essential for doctors as for other people. Socialized medicine, increased work load and smaller income discourage able and ambitious people from studying medicine.

American medicine is the finest in the world. It did not attain high standards by federal aid or government planning. Outstanding results were achieved by medical societies, universities, local communities and the states.

This kind of joint activity is the American way in medicine. When New Frontiersmen try to impose a version of the British system, the public should know the result will be poorer care for the sick.



ANNUAL CONVENTION

The annual meetings of the S. C. Medical Association and the Auxiliary at Myrtle Beach May 8, 9 and 10 were covered by two members of Tobias & Co. On-the-spot news stories and photographs were relayed to news wire services throughout the three-day session.

Prior to the meeting pre-convention news stories and mats of officers and guest speakers were sent to principle newspapers, radio and television stations. Scientific papers presented at the convention and photographs of the event will appear in future issues of the Journal.



TOWN MEETING

Throughout the nation there is a revival of town hall meetings for open discussions of national and local matters of importance to the community. It is suggested that the organization of such a meeting by members of the local county medical societies could go a long way toward clearing up any points of confusion on the pending King-Anderson Bill and could emphasize the good work being done by the present Kerr-Mills law.



STUDENT INQUIRIES

Recently the chairman of the public relations committee and Tobias & Co. have received student requests for factual materials on the King-Anderson Bill and the results of socialized medicine in England. These materials are being used in class assignments. By filling their requests the medical profession has an excellent opportunity to reach young people, and to help them see beyond the New Frontier's rosy image of compulsory medical care under Social Security. These students are the voters of tomorrow. Their votes may well determine the future of medicine in the United States. Within the radius of your county society there may be students who are interested in similar materials. These may be ordered in small quantities through the Public Relations Committee. Bulk orders will be transmitted to AMA.

Key to Recordings & Speeches



RADIO TAPES

#1. Dr. Charles N. Wyatt, King-Anderson Bill.

#2. Quotations—Congressman Bryan Dorn and prominent S. C. newspaper on King-Anderson Bill.

#3. King-Anderson Bill, informal down-to-earth discussion.

#4. An expose of Quackery.

#5. Dr. James H. Gressette on King-Anderson.

#6. Quotations—Strom Thurmond on King-Anderson.



SPEECHES

#1. King-Anderson Bill versus Kerr-Mills Law.

#2. Food Faddism.

#3. The Rising Cost of Hospitalization.

#4. Hidden Hazards (Household poisons).

#5. The Care & Preservation of the American Businessman.

#6. Mental Health.

#7. Medicine as a Career.

#8. Seven Ways to Cut Your Medical Expenses.

S. C. Medical Association
Public Relations Committee
P. O. Box 275, Charleston, S. C.

Please send the following

RADIO RECORDINGS

☐ #1 ☐ #3 ☐ #5
☐ #2 ☐ #4 ☐ #6

SPEECHES

☐ #1 ☐ #5
☐ #2 ☐ #6
☐ #3 ☐ #7
☐ #4 ☐ #8

SPEAKERS BUREAU KITS

☐ (Quantity)

PAMPHLETS (Quantity)

☐ The Cost of Medical Care (1940-1960)
☐ Medical Aid for Aged
☐ Helping Those Who Need Help
☐ Socialized Medicine and You
☐ A Family Doctor's Fight
(Reprint, *Look* Magazine)

NAME_____

ADDRESS_____

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BASIC FACTS ABOUT THE AMERICAN MEDICAL ASSOCIATION

(Continued from March Issue)

A. M. A.'s ACCOMPLISHMENTS

For more than a century, the American Medical Association has dedicated itself to furthering the interests of the nation's health and has developed a large number of activities, all of which directly or indirectly have contributed to making America one of the healthiest nations in the world.

Since its organization, in 1847, there has been no major public health problem in the United States in which the A. M.A . has not played a significant role.

To enumerate all of the Association's accomplishments would require a huge volume. Listed here are highlights of a cross-section of these contributions:

MEDICAL EDUCATION

Since 1847, A. M. A. has worked to improve the nation's medical schools. Its activities led to the housecleaning between 1905 and 1920 of medical "diploma mills." Since then, A. M. A. and the Association of American Medical Colleges have periodically inspected all schools to make certain high standards are maintained.

Every year A. M. A. compiles and publishes valuable data encompassing all facets of medical education.

It sponsors an annual Congress on Medical Education and Licensure.

As early as 1922, A. M. A. recognized the need for more medical schools and has encouraged the expansion of existing facilities and the construction of new ones.

In 1871 A. M. A. took the first step toward certifying boards for specialists.

Four years later it urged endowments to medical schools.

Through the American Medical Education Foundation (AMEF), physicians have contributed voluntarily since 1952 more than $10 million to aid medical schools. These funds, "with no strings attached," can be used by schools in any way they see fit. The 1960 physician contribution was $1,172,618.

A. M. A. approved "evaluation of the medical qualifications of the individual foreign-trained physician who wishes to come to the U. S." and "considers certification by the Educational Council for Foreign Medical Graduates (formed in 1957) as evidence that the recipient of certification is possessed of medical knowledge comparable to that expected of graduates of approved medical schools in the U. S. and Canada . . ." To assure the best possible medical care for all the people, the Association expects all graduates of foreign medical schools serving as interns or residents in U. S. hospitals to have been certified by ECFMG.

Because of these continuous efforts to elevate medical education standards, America's physicians are among the best trained in the world.

ACTION AGAINST QUACKERY

Carrying out one of the original purposes of A. M. A. is the Department of Investigation which, since 1906, has carried on a relentless fight against quacks and charlatans and their nostrums and gadgets. The Department, which has the largest files existent on medical quackery, has been most effective in revealing facts concerning unethical and fraudulent practices and in providing regulatory bodies with evidence leading to conviction. Consequently over the years A. M. A. has been sued for several million dollars in damages. It lost but one case and damages of 1¢ were awarded.

GUIDANCE ON DRUGS

Another of A. M. A.'s major accomplishments has been its long and constructive influence in behalf of greater scientific accuracy and more dependable therapeutic agents. A year after A. M. A. was founded, 1848, a resolution pointed out the dangers of universal traffic in secret remedies and patent medicines. A. M. A.'s leadership, backed by certain standards of discipline brought about new concepts of pharmaceutical integrity. A. M. A.'s Council on Drugs was established in 1905, primarily to police the widespread drug advertising which promoted false claims and secrecy of formulae. To this day, A. M. A.'s publications have rigid standards governing the acceptance of advertising.

As early as 1849, A. M. A. supported establishment of schools of pharmacy, establishment of a board "to analyze quack remedies and nostrums" and "to enlighten the public in regard to the nature and dangerous tendencies of such remedies." Passage of pure food, drugs and cosmetics laws were in large measure attributable to effects of A. M. A. In 1905, the Council on Pharmacy and Chemistry was created to analyze drugs, publishing the results.

The A. M. A. provides physicians with early unbiased information on all types of new drugs and prepares special reports on the current status of therapy in disease.

The Council's motto "not for ourselves, but for medicine," characterizes its efforts over more than a half century in behalf of better medicine.

MEDICAL SERVICE

In 1943 A. M. A. established a Council on Medical Service "to make available facts, data, and medical opinions with respect to timely and adequate rendition of medical care to the American people." The Council's accomplishments have been numerous and noteworthy.

Its many constructive programs have included:

Development of voluntary health insurance and pre-payment plans as the best mechanism for paying for medical and hospital care. (A. M. A. first began study of health insurance in 1913).

Development of guides for evaluating medical care programs for those financially unable to pay their own way and continually seeking ways to improve existing

plans while maintaining high quality care.

(The medical profession is dedicated to the provision of medical service for all, regardless of ability to pay. On the average, an MD donates about 12½% of his time to providing free care. In 1960 physicians gave approximately $658 million in free medical care. Source: *New Medical Materia* national survey.)

Better distribution of medical services through a physicians' placement bureau, programs to help communities to attract doctors, and a cooperative program with Sears-Roebuck Foundation to help MDs set up practice in rural communities or small towns. (190 communities have been surveyed and 23 doctors were placed in small towns in 1960 alone.)

Serving as a watchdog of medical standards for government or allied agency health programs, offering guidance and endorsing policies and procedures which will provide best quality medical service in the long run.

Providing better patient care by working with other groups to maintain high hospital standards; by encouraging construction of nursing homes; by continually seeking ways to improve and expand existing programs for providing and financing care for the chronically ill; by supporting and helping to implement federal-state legislation which enables every state to guarantee to every aged American who needs help the health care he requires; by drafting a positive health program for older citizens which included: stimulation of a realistic attitude toward aging by all people, promotion of health maintenance programs and wider use of restorative and rehabilitative services, extension of effective methods of financing health care for the aged, expansion of skilled-personnel training programs and improvement of medical and related facilities for older people, amplification of medical and socio-economic research in problems of the aging, leadership and cooperation in community programs for senior citizens.

FOODS AND NUTRITION

A. M. A. provided early leadership in the movement to make proper use of vitamins and minerals to improve the nutritive quality of staple foods. In 1915 it participated in helping improve the quality of milk supplied to the nation. It played an important role in fortifying milk with vitamin D, which became a principal factor contributing to the decline of rickets in this country; in developing enriched flour, one of the notable public health movements of that decade; in developing iodized salt; fruit juices containing high natural levels of vitamin C, and canned baby foods.

Rapid expansion of the science of foods and nutrition since the turn of the century has been dramatic and far reaching in its applications and A. M. A. made a vital contribution in this development.

ETHICAL CONDUCT

One of the paramount reasons for founding the A. M. A. was to develop an accepted code of ethical conduct for physicians. The present A. M. A. *Principles of Medical Ethics* have been evolved through the years by action of the House of Delegates. These principles, which are "not laws to govern but are principles to guide to correct conduct," contain much specific advice on how to maintain ethical relations with patients and with other physicians. They have been set down primarily for the good of the public, but they also serve as an inspiration to the physician to remain true to his oath.

In addition, the *Principles of Medical Ethics* are augmented by the interpretations of the A. M. A. Judicial Council. These interpretations are published in the *Journal of the A. M. A.* and compiled periodically in the *Opinions and Reports of the Judicial Council.*

BOARDS AND DEPARTMENTS

A. M. A. has fostered public health facilities throughout the nation. Eighty-nine years ago it urged establishment of state boards of health. Two years later it worked for formation of a complete system of state and county medical societies and an international medical society. As early as 1912, A. M. A. urged establishment of a department of health in the President's cabinet, which later led to the Department of Health, Education and Welfare. It also recommended creation of the U. S. Public Health Service, the Federal Food and Drug Administration, and in 1948 participated in the development of the World Medical Association.

SCIENTIFIC EXHIBITS

Physicians attending the 1899 A. M. A. meeting saw the first scientific exhibit at a national medical meeting in this country. The exhibit was on pathology and caused so much comment that scientific exhibits soon became one of the most significant and important developments for the advancement of medical science. Today there are from 350 to 400 scientific exhibits at A. M. A.'s annual and clinical meetings.

HEALTH EDUCATION

In 1882 the A. M. A. urged state legislatures to "introduce hygiene as one of the branches to be taught in the schools." Today, through a long and mutually profitable joint committee with the National Education Association it edits a standard textbook on the teaching of health in the schools.

Its staff physicians answer questions on school health from educators and schools, it sponsors conferences on physicians and schools, and maintains a year-round school health program.

In 1878 A. M. A. urged better education of the public in regard to health. Through continuing programs of public education and communication, the American people today know more about their health and how to preserve it than ever before. A. M. A.'s activities in this area include exhibits, films, pamphlets, radio and TV programs, *Today's Health* magazine, articles in newspapers and magazines, conferences and meetings, and a letter-answering service.

LEGISLATION

Another important way in which the A. M. A. paves the way toward better health care for the people is by supporting sound medical legislation and by opposing measures which it believes would lower the quality of

medical care or would not be in the best public interest.

Through its Washington office, Legislative Department, and Council on Legislative Activities it analyzes all legislation pertaining to medicine and health and supports far more legislation than it opposes.

In recent years it has supported:

The Kerr-Mills Medical Aid for the Aged Law passed in 1960 and worked actively towards its implementation in the states.

Hill Burton hospital construction program.

The passage and strengthening of the pure food and drug laws.

The White House Conference on Aging in 1961.

FHA mortgage guarantees to stimulate construction of more nursing homes.

The principle of legislation calling for one-time federal grants with no strings attached for construction of medical school facilities.

Civil defense programming and medical stockpiling.

Water pollution control laws.

Incentive for private retirement programs for the self-employed.

Smoke abatement laws.

Proper labeling of household chemicals.

Air pollution control law.

Tax deduction for medical expenses incurred on behalf of dependent parents over 65.

Grants-in-aid to universities, hospitals, laboratories and other public or non-profit organizations to strengthen their programs of research and research training in sciences related to health.

A bill which would provide for the regulation of inter-state distribution and sale of hazardous substances intended or suitable for household use.

Endorsed the principle of a program of voluntary, contributory health insurance for federal employees.

During the 86th Congress, A. M. A. issued 43 statements on 25 bills, of which only six on four bills were in opposition to the legislation. 11 were informational and 26 were in support of legislation. In the 85th Congress, 700 bills affecting medicine directly or indirectly were introduced. The A. M. A. testified on 28 measures, supporting 19 and opposing six. Testimony on the others was purely informational. Through the years A. M. A. has recommended hundreds of legislative proposals, including the following:

Recommended in the 1850's adoption by state governments of "measures for procuring a registration of births, marriages and deaths." And since then has supported measures for securing standard nomenclature and more efficient reporting of vital statistics.

Its efforts paved the way for passage of food, drug and cosmetic laws.

Supported the medical examiner system to replace the antiquated coroner system.

Recommended in 1874 that people should not be allowed to marry until they obtain a certificate showing that they did not have syphilis.

In 1903 A. M. A. was concerned about excessive injuries caused by fireworks and started a campaign which led to laws regulating the use of fireworks in celebrating the Fourth of July.

It opposed repeal by Congress in 1916 of the Daylight Saving Act expressing an opinion that the act was "wholly beneficial to national health because it lengthened the hours of recreation in the open air."

In 1874 it determined the most feasible plan for securing legislation to prevent the spread of syphilis.

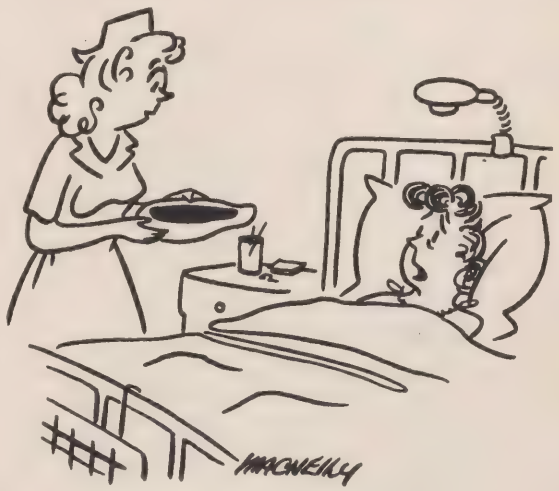
As early as 1884 it supported experimentation on animals as the most useful source of knowledge in medical practice. (If policies of restriction and prohibition had been followed, they would have forbidden the discovery of antitoxin, insulin, and a number of other valuable agents whose therapeutic properties were humanely demonstrated on laboratory animals.)

It recognized the weakness in the antinarcotic law of 1914, which permitted sale and use of narcotics when contained in proprietary and stock preparations, and urged Congress to amend the law. Its close review of all health legislation has resulted in similar findings through the years.

In 1860 it urged action by legislatures in every state against illegal abortion.

A. M. A. also has proposed model laws for consideration by state legislators such as measures to authorize post-morten examination and blood test regulations.

Since passage of a law is just one step toward putting it into effect, much of the further interpretation of the law, promulgation of regulations and determination of practical policies fall to the administrative agencies concerned. A. M. A. works closely with these offices in an advisory capacity—just one further indication of its concern for the advancement of public health in America.



"GOOD HEAVENS! I MUST BE USING THE ASH TRAY!!"

MISCELLANEOUS

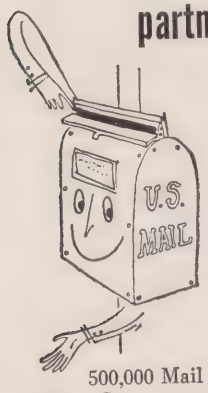
Other A. M. A. accomplishments include encouragement of medical scientific research and its own allocation of hundreds of thousands of dollars for fundamental investigations . . . one of five organizations making up the Joint Commission on the Accreditation of Hospitals which is responsible for the inspection of hospitals . . . inspection and approval of schools for laboratory technicians, occupational therapists, physical therapists, x-ray technicians, and medical record librarians . . . early studies and recommendation for preventive measures for controlling diphtheria, typhoid fever, cholera, smallpox, tuberculosis and other diseases that caused epidemics in the last century . . . endorsement of the principle of fluoridation of community water supplies . . . condemnation as dangerous the indiscriminate administration of stimulants such as amphetamine and its derivatives . . . its work toward prevention, amelioration and treatment of athletic injuries . . . first to recognize the refrigeration method of anesthesia.

. . . its studies and reports on devices manufactured and sold for use in physical medicine . . . its work in the fields of traffic and industrial safety. (In 1954 the A. M. A. recommended to automobile manufacturers that they consider equipping all cars with safety belts, that they give increasing emphasis to safety in design of all cars.)

The A. M. A. has developed, and brought to maturity, scores of other constructive reforms and advancements, all of which are part of the printed record.

The American Medical Association stands for honesty and fairness and is unalterably and eternally against fraud and deception in all that relates to the health and physical welfare of the people.

put 'er here, partner!



500,000 Mail boxes in the United States are your partners in the fight against cancer.

A contribution addressed to "Cancer" c/o your local post office will help guard your family, yourself and your community.

Next time you see a mail box, "put 'er there, partner!"... as generously as you can.

AMERICAN CANCER SOCIETY

Here is my contribution of $..... in support of the Cancer Crusade.

Name.....

Address.....

City.....*State*.....

There are about 28,000,000 Americans, or about one in six persons in this nation, with some degree of disability, according to *Patterns of Disease*, a monthly Parke, Davis & Company publication for physicians. These are persons "whose activity is limited by chronic conditions," of which chronic disease is the leading cause, accounting for about 88% of those disabled. Accidents at work account for 5%, and accidents at home and on the highway along with other accidents account for another 5%, while congenital conditions cause about 2%.

Of the approximately 28 million disabled Americans, (about one in six) more than 17 million are limited in their activity as workers, students, or housewives, and almost 5 million are confined to their homes or cannot move around freely, or have trouble doing so without assistance, according to *Patterns of Disease*, a Parke, Davis & Company publication for physicians. "It is estimated that more than 2,000,000 persons need, and could profit, from vocational rehabilitation services and that 270,000 persons are added to this group annually," *Patterns* adds.

Professional personnel available to treat the approximately 95,000 patients now being rehabilitated include 507 physicians, 5,000 medical social workers, 6,000 speech and hearing therapists, 6,259 occupational therapists, 6,413 physical therapists. If 10 million disabled persons were to receive care, it "would require 12% of the total available time of every nurse and physician in the nation. In addition to those already working in physical medicine and rehabilitation, 43,000 physical therapists, 44,000 occupational therapists, and 20,000 other paramedical workers would be needed," according to *Patterns*.

THE ADVANTAGES OF THE AMERICAN FREE ENTERPRISE SYSTEM OVER COMMUNISM

A winning essay in a contest sponsored by the American Association of Physicians and Surgeons and by the South Carolina Medical Association.

by
Carolina Clower
Chesterfield, South Carolina

Being a combination free-lance writer and social worker in Berlin for the past five years, I had grown to love and respect Germany and her people.

Now, I was going home to be married, and I wanted to spend my last day revisiting the places that I had loved. I decided to go to Tiergarten and Congress Hall first. Then I would go to the banks of the Spree, the Kurfurstendamm (the fashionable shopping street), the National Gallery, the Prussian State Library, and Charlottenburg Palace. I wanted to walk along, remember my happy hours, and think about home. Although I never completed my plans, my last day was the most interesting and inspiring that I ever spent in Berlin.

As I sat down on a park bench in Tiergarten, an attractive young woman walked up to me and sat down. She asked, with an accent I immediately recognized as Russian, "Are you not an American?"

I replied, "Yes, I am. My name is Louisa Mallory, and I have been in Berlin for five years. Who are you and where did you learn English?"

She answered, "I am Anna Volpishi, a Communist, and I learn to speak English in Moscow.

"I am a student of economics and political science. I have been a Communist spy since I was fifteen, and I just return from the United States where I observed the free enterprise system of your 'capitalist' country.

"I had no opportunity to talk with any citizens of your country, so when I saw you, I decided to ask you some of my questions. Do you have a few minutes to spare?"

Almost too shocked to answer, I must have said, "Yes," because Anna instantly began to lecture and question me about our economic system. When I recovered from shock, I realized that I had a full year's job to complete in a few short hours. Then I became aware of what Anna was saying.

"The United States," she stated, "has a well-developed industrial system, but I don't see why your workers don't revolt. Capitalism takes most of the worker's earnings and makes him work long, hard hours. Communism corrects this error; I just don't understand why more laborers are not members of the party . . ."

"Anna, hold on just one minute," I interrupted. "If you really want to know the true answers, come with me to the U. S. Embassy for some pamphlets and bulletins put out by our government. On the way over, I'll explain a little."

As we started our walk, I talked about the American free enterprise system. "Did you know that it takes four and one-half hours of work in Russia, as opposed to one hour of work in the United States, to buy eighteen of the items essential to family life?

"How much does a dozen eggs cost in Russia — in American money?" I asked.

"Oh, I say about three dollars," she answered casually.

"And those same eggs would cost sixty-five cents in America, Anna," I explained.

Though she looked at me in disbelief, I continued, "In Russia a pair of leather shoes would cost eighty dollars, while in the United States they would cost eighteen dollars. A wool suit costs from $250 to $400 in Russia; a wool suit in the U. S. costs sixty-five dollars."

Just as I finished this statement, we arrived at the embassy. I left Anna at the door to think, while I went to get the necessary pamphlets. I fully expected Anna to be gone when I returned, but she was there waiting — in deep concentration.

She did not hear me when I walked up to her, so I tapped her on the shoulder. She jumped and exclaimed, "Oh, Louisa, you startled me."

I answered earnestly, "I am sorry. Here are some articles published in the United States about our economic system. I want you to read these and ask me any questions you have. I am no expert, but I will do my best."

During the next hour Anna silently pored over the articles, while I read the latest edition of the *New York Times*.

"Louisa," Anna began finally, "my leader has never told me such things; he has said only that the workers of America are much worse off than the Russian workers and that America is a country with no prosperity, only poverty. He claims that by 1980 Russia will have passed the 'backward' United States by leaps and bounds."

"You see, Anna, that is one of the things our government is trying to discredit now," I said; "We would like for the truth to reach your people; then they would know for themselves that the free enterprise system of the United States is best for the people and for the government."

"Now, just a moment, Louisa," she hastened. "I didn't say that your system is better. I only meant

that I do not understand how a system like yours works. Please explain."

"Well, to begin with," I replied, "our government, thus our economic system, is based upon these thoughts: 'We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness.' The United States was built upon this foundation, and the cornerstone was the belief in the worth of the individual.

"Russia is not based on any such outstanding principle. The individual is not considered at all. He is only for the good of the state. His wishes and desires are minor things. He may even disappear if he disagrees with the government.

"Students, laborers, farmers, etc. are told what to do, when to do it, how to do it, and where to do it. Like you, I bet that the state told you to major in economics and to travel to the U. S. Did you have any choice?"

When Anna shook her head silently, I continued. "That isn't the way anything is done in the United States. We believe that every man has a right to do what he wants and when he wants, within the limit of the law. Each man and woman has the opportunity to decide what job he wants and where he will work at this job. Of course, he can't open a business without abiding by the laws the government sets forth, but he may open any business he thinks appropriate.

"The laborers in factories are members of a union, and if they become unhappy, they may protest or go on a strike.

"In Russia you have unions of a type, but they are used as a method of thrusting the laborers closer to communism. They aren't for the personal good of the laborer."

"But all of this doesn't tell me why you produce more products or . . . ," piped Anna.

"Our system of allowing one to pick his occupation gives the worker the incentive to work hard and produce more goods. Our laborers want to work hard because they are paid more, and they can advance to higher positions if they do work hard.

"Your people don't want to work hard because most of them have been pushed into a job that they had no choice about. They can't advance unless they're Communists, and they don't get paid more money for harder work.

"As you see, our free enterprise system allows for choice and thoughts. Your economic system is only for the good of the all-supreme state."

When I glanced at Anna, I feared that my case was lost, so I quickly ended. "Anna, I could go on forever, but if I haven't already convinced you, then I can't do it by talking any longer. I hope I have helped open your eyes to the truth about my country.

As Anna looked up, I saw that her sad, troubled expression had turned to an expression of belief. She grasped my hands, and her final words before she left were, "You have made me see the light about Communism, and I want to thank you graciously. I shall never spy on America again. I am going to get my family out of Russia forever. My only remorse is that all Russians can not hear you talk and see the pamphlets that I have read — the world would change in an hour. Goodbye and — G-God bless you."

As Anna disappeared, I thought, "I know now that the world would emerge from the cold war if all the Russians had available to them these few pamphlets, if the Russians just know the truth about the free world."

Then before I left Tiergarten, I stepped inside Congress Hall and read the words of Franklin engraved at the entrance. "God grant that not only the love of liberty but a thorough knowledge of the rights of man may prevade all the nations of the earth, so that a philosopher may set his foot anywhere on its surface and say, 'This is my country.' "

MARKLE FOUNDATION

Questions Massive Federal Support of Medical Research

The amount of money the government is giving to support the research programs of medical schools is affecting teaching and other functions of the schools adversely, John M. Russell said in the annual report of the John and Mary R. Markle Foundation.

"Because Government grants have concentrated so heavily on the encouragement of research and because medical schools have the facilities and personnel to conduct research, most of the money in the bio-medical field has gone their way. However, medical schools have other equally important jobs to do, such as training, education and service. Research is only one cylinder in the medical school motor. As a matter of fact, medical research itself won't get very far in the future if medical schools are not kept running on all of them. With grants for research projects, research facilities, research trainees, research equipment, research personnel and for anything in any way, shape or form, as long as they are for research, the 'central function' (which is education) and the 'proper internal balance' (among their major responsibilities) of medical schools have been seriously distorted. As matters stand, the medical school motor is not hitting on all cylinders and is in need of a tune-up. Uncle Sam's tinkering is not helping matters very much.

"The overemphasis on research and the conse-

quent distortion of the medical school's function are natural results of the post-war preoccupation with attempts to solve various dreaded diseases by direct attack. This is the popular approach, which has been reflected in the Congress by larger and larger appropriations. Congressional committees have received reams of testimony urging such action—testimony given with the very best of intentions. The action taken by Congress has also been with the best of intentions, for in the area of health especially, they want to do the right thing."

MORE FUNDS TO COME

Reports in "newspapers and scientific and medical journals" indicate that "the new administration is prepared to pour even more money into research than ever before; that countless scientists are spending countless hours deciding who gets what; that the National Institutes of Health is not satisfied with the way applications are handled and believes that the trouble will be corrected by a rearrangement of its bureaus; that our great universities are beginning to feel dangerous pressures from Washington."

GOVERNMENT AND HIGHER EDUCATION

"All higher education seems to be slightly uncomfortable over its relations with the Federal Government and vice versa. Alma Mater and Uncle Sam are eyeing each other closely." A sign of this discomfort is "the urge (on the part of educational agencies) to establish a lookout in Washington to keep an eye on the government."

"The present advisers to Congress often fail to understand the dependence of research on education and the dangers to both when the functions of medical schools are thrown askew." The report suggests that the ways through which Congressmen get advice on legislation affecting medical education should be broadened. "It may be that this problem can only be dealt with at the university level—that the university presidents, not the medical school deans, are the ones to carry the message to Congress."

The report praises bureau chiefs of the National Science Foundation and the National Institutes of Health, who have helped to allot millions of dollars of government funds to medical institutions "for their care in avoiding attempts to influence and control activities within medical schools. Conscious of the widespread fears of government control, they have designed their programs in support of research with the greatest care... and, in methods of administration, have been as liberal as they are allowed under the law."



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Book Reviews

HYPERTENSION — RECENT ADVANCES. THE SECOND HAHNEMANN SYMPOSIUM ON HYPERTENSIVE DISEASE. Edited by Albert N. Brest and John H. Moyer. Lea & Febiger, 660 pages, Philadelphia, 1961. $12.00.

This compilation of papers from a four day symposium held in May of 1961 on recent advances in the knowledge of hypertensive diseases covers a great deal of material. Many of America's best known authorities have contributed to the papers and discussions. Sections of the book treat the natural history of hypertensive disease, various theories of its etiology, the relation of hypertension and atherosclerosis. There is an extensive section on the pharmacology of the currently used antihypertensive drugs. Current knowledge of cactecholamine metabolism and drugs which affect it is reviewed in detail. There is also a detailed discussion of various modes of therapy in a variety of hypertensive diseases. This makes up the last third of the book. There is something of interest in this text for everyone concerned with the subject of hypertension. A possible criticism is that so much is covered that nothing is treated in depth. The book does, however, bring one up to date on the thinking of many who are deeply immersed in investigation of various aspects of hypertensive disease, and as such, serves its function as, although predigested, a major review of the current literature on the subject. Especially noteworthy are Sokolow's chapter on the natural history of untreated hypertensive disease. Hoobler's chapter on the mechanism of hypertension, the material of Genest, Tobian, Laragh on the relation of angiotensin to aldosterone, the exciting data of Smeby and Bumpus on the biochemistry of angiotensin, the section by Stamey, Burrows, and Morris on the diagnosis of renal vascular obstruction and selected portions of the sections on pharmacology and treatment. This book can be widely recommended to all students of the subject of hypertensive disease ranging from medical student to expert.

C. M. Smythe, M.D.

THORACIC DISEASES (Emphasizing Cardiopulmonary Relationships). By Eli H. Rubin, M.D., and Morris Rubin, M.D., W. B. Saunders Company, Philadelphia and London, 1961. Price $25.00.

This lengthy volume, of almost one thousand pages, contains a vast amount of authentic information on pulmonary diseases primarily. There is also an extensive discussion on the normal and abnormal physiology of the heart and lungs throughout the volume. While the information contained in the book is all excellent, it would seem to be poorly arranged. For instance, there is no chapter or section on diseases of the heart itself. There is no discussion on the diagnosis or treatment of diseases of the heart or of those which are amenable to surgical treatment, although subjects such as cardiac catheterization and angiocardiography are given detailed attention. The material relating to diseases of the mediastinum is scattered in at least three different sections of the book. Interestingly enough, there is no chapter or section relating to diseases of the esophagus. Possibly the main comment on the book is that the title is misleading. However, for bronchopulmonary disease, the book is splendid, although it is believed that it is poorly arranged in that the information pertaining to any one particular subject may be found disseminated in several parts of the book. Even so, the book could be recommended for anyone with special interest in bronchopulmonary disease.

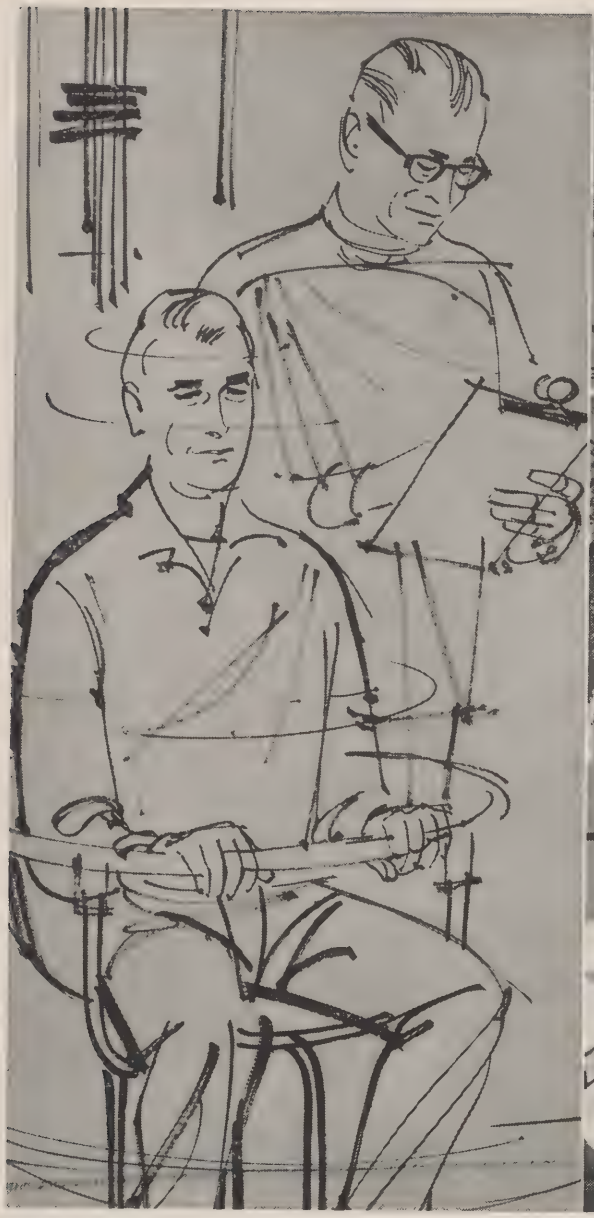
Edward F. Parker, M.D.

CLINICAL METHODS OF NEURO-OPHTHALMOLOGIC EXAMINATION. By Alfred Kestenbaum, M.D. Grune & Stratton, second edition 1961. 513 pages. $16.75.

This book has value, not only to ophthamologists, but to phychiatrists as well, in view of the fact that there is an excellent section at the end of the book dealing with functional disturbances of the eye as related to psychological disturbances affecting general eye function.

This is the second edition of another book written ten years ago in which there are two main additions: newer methods of ophthalmologic examinations, and the application of these newer methods of examination for determining various degrees of psychologic disturbance, particularly the precise clinical methods of determining the presence or absence of hysteric and malingering phenomena. There is a very interesting section dealing with the use of optokinetics for determining special types of nystagmus. This method is valuable in diagnostic determination for psychologic disorders demonstrating ophthalmologic pathology.

The author is a precise, scrupulous worker, who has a deep understanding of emotional factors as they may portray themselves in special types of eye symptoms. Although his book is very specialized, it could be of great value to those psychiatrists and ophthalmologists who are interested in demonstrating clearly and precisely how to be more certain of their diagnostic criteria





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Norton L. Williams, M.D.

PROGRESS IN LIVER DISEASE. By Hans Popper, M.D. and Fenton Schaffner, M.D., Grune and Stratton, New York and London, 1961. $13.75.

Although this is a book designed to survey the progress in the field of liver disease and will appeal more to those devoting a considerable part of their time in practice to problems related to the gastrointestinal tract, the fact that in the past two or three years so many advances have been made in a better understanding of the structure, function, pathological anatomical changes and etiology of various previously known and more recently defined hepatic disorders, it is a book which should be readily available to all physicians as a reference source and guide towards a better understanding of useful diagnostic methods and for planning rational therapeutic programs.

The format and content of the book are considerably different from Dr. Popper and Dr. Schaffner's previous book on Liver Structure and Function, which work was composed by the two authors entirely. In this volume they edit the work of some 36 others from throughout the world who have contributed various sections; it does however serve as a companion volume to the previous book.

There are excellent chapters covering the newer knowledge of hepatic necrosis, post-necrotic cirrhosis, autoimmunity in liver disease, liver disease in infancy and childhood, studies in pathogenesis, hepatic coma, hepato-renal syndromes, bilirubin metabolism, the various hepatic enzyme systems, and some of the newer radiographic and other diagnostic techniques are discussed in considerable detail.

This particular volume is labeled as Volume I, and undoubtedly at reasonable intervals we will probably expect to see additional Progress volumes being brought out.

Vince Moseley, M.D.

THE DYNASTY: A Medical Novel. By Charles H. Kickerbocker. Doubleday and Co., Inc. Garden City. 1962. $4.50

Written by a practicing physician who has two novels and many articles already to his credit, this book presents a credible picture of the life of a young doctor who becomes involved in the life and family of an old established physician in a small town. The old physician is really the most striking figure of the book. He is dynamic, popular, hardworking, successful, but not always competent in the light of currently applied medicine. His virtues and his vices are well delineated.

The book offers an opportunity for various remarks concerning the questionable efficacy of present day "high level" teaching, and the lack of knowledge of the practical approach in the young graduate. There is a word against Federal control of medicine, and pertinent comments on various phases of the profession, but the book is not propaganda, but rather a story to be read and enjoyed. There are not many dramatic or inspiring passages, but the narrative maintains a comfortable but not brilliant course throughout the book.

J. I. W.

MEDICAL GENETICS 1958 — 1960. By Victor A. McKusick, M.D. The C. V. Mosby Co. St. Louis. 1961. pp. 534. $14.50.

McKusick and his colleagues in the Johns Hopkins University School of Medicine, have accomplished the monumental task of preparing an annotated review of the literature in medical genetics for the years 1958, 1959, 1960. This was published in the **Journal of Chronic Diseases** (Vol. 10, 12, 14) and recently republished in book form. The book is a scholarly and critical review. It should be useful to physicians who are seriously interested in keeping up with advances in genetic aspects of their own fields. Because of its organization and a cumulative index, the book is easy to use.

It is divided into three sections, each covering the literature from one year. Each section is subdivided and arranged alphabetically according to subject (biochemical genetics, blood and hematopoietic system, cardiovascular system, etc.). Certain papers, deemed important by McKusick, are reviewed in detail; others are merely mentioned. (His judgment is excellent.) One book is included only to condemn it!

When one notes the number of papers listed at the end of each yearly review (over 600, 900, 1100, respectively), one must conclude that the interest in medical genetics is increasing rapidly.

Elsie Taber, Ph.D.

ATLAS OF HEAD AND NECK SURGERY. John M. Lore, Jr., M. D. W. B. Saunders Co. Philadelphia. 1962. $25.00.

Doctor John M. Lore, Jr., in his Atlas of Head and Neck Surgery, has presented us, under one cover, with a very complete atlas encompassing all of the ramifications of head and neck surgery which have been developed in the last decade. The need for this type of book is obvious when one considers that in recent years investigation into head and neck surgery by otolaryngologists, by oncologists, and plastic surgeons has stimulated a tremendous amount of interest in surgery in this area.

The book is beautifully illustrated and the descriptions are very concise and to the point. The book is heartily commended to those who have an interest in the surgery in this area.

R. W. Hanckel, M. D.

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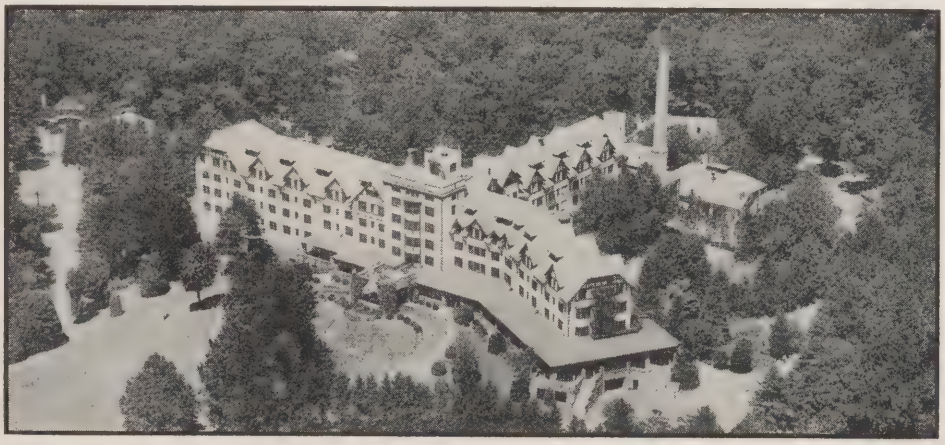
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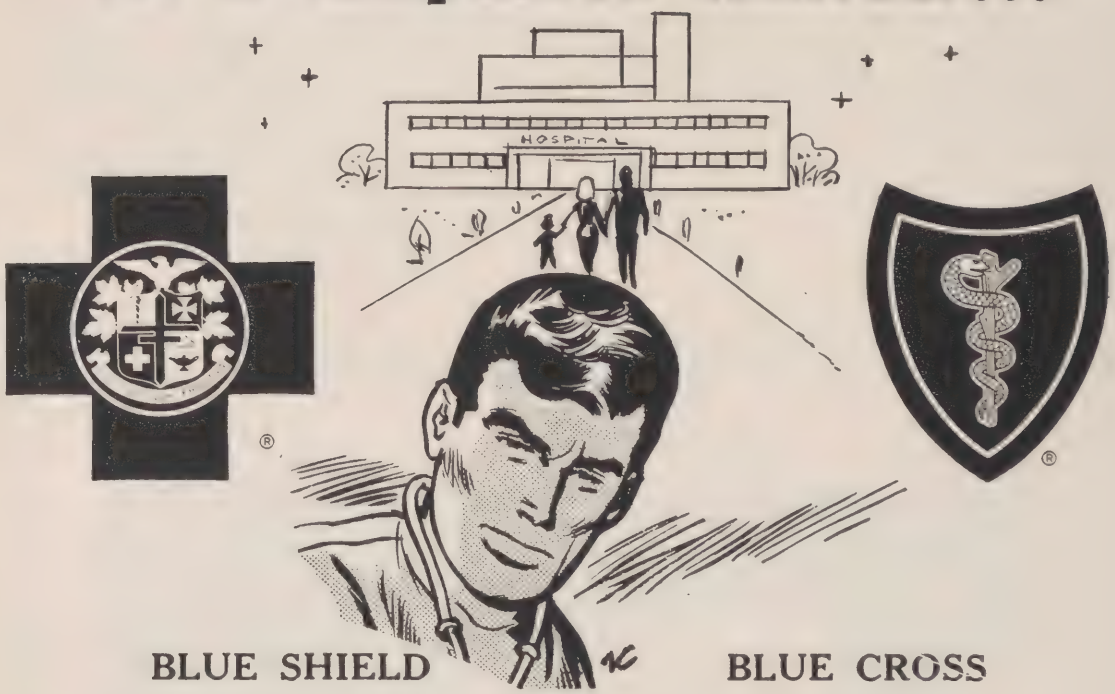
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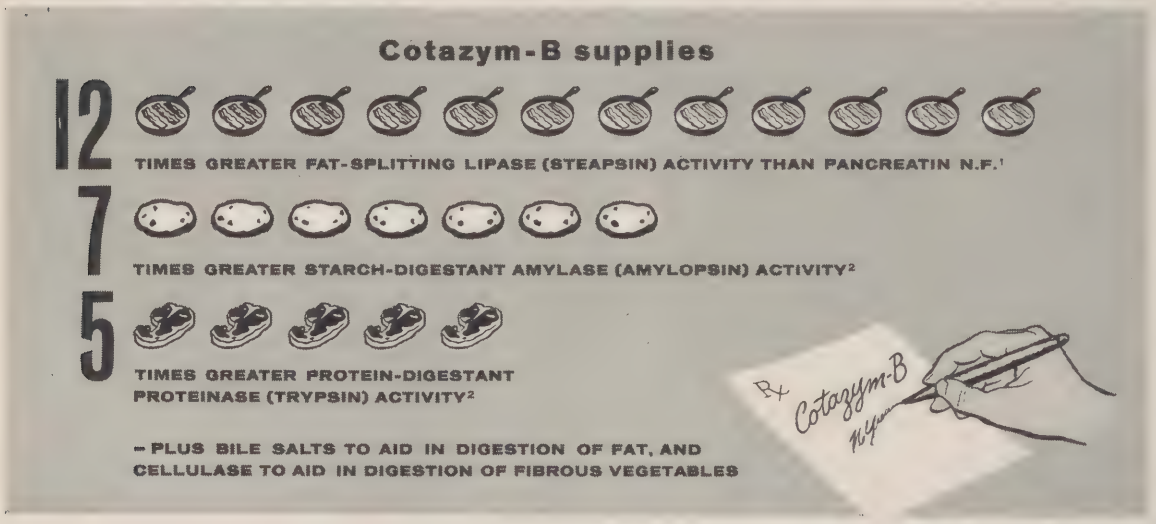
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ORGANON INC., WEST ORANGE, NEW JERSEY

Cotazym®-B

Lipancreatin Bile Salts Cellulase



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

gratifying relief for painful joints



With ARISTOCORT, *patients with painful, arthritic joints obtain rapid reduction of pain and inflammation, as well as substantial improvement in joint mobility. Many patients who might otherwise be confined in a state of invalidism have been able —with* ARISTOCORT—*to continue their customary livelihoods or go about their regular household activities.*

Yet this gratifying symptomatic relief may not be accompanied by severe hormonal collateral effects, such as sodium retention, edema, emotional disturbance, insomnia or voracious appetite—that may prevent patients from obtaining corticosteroid benefits.

unsurpassed for total patient benefits

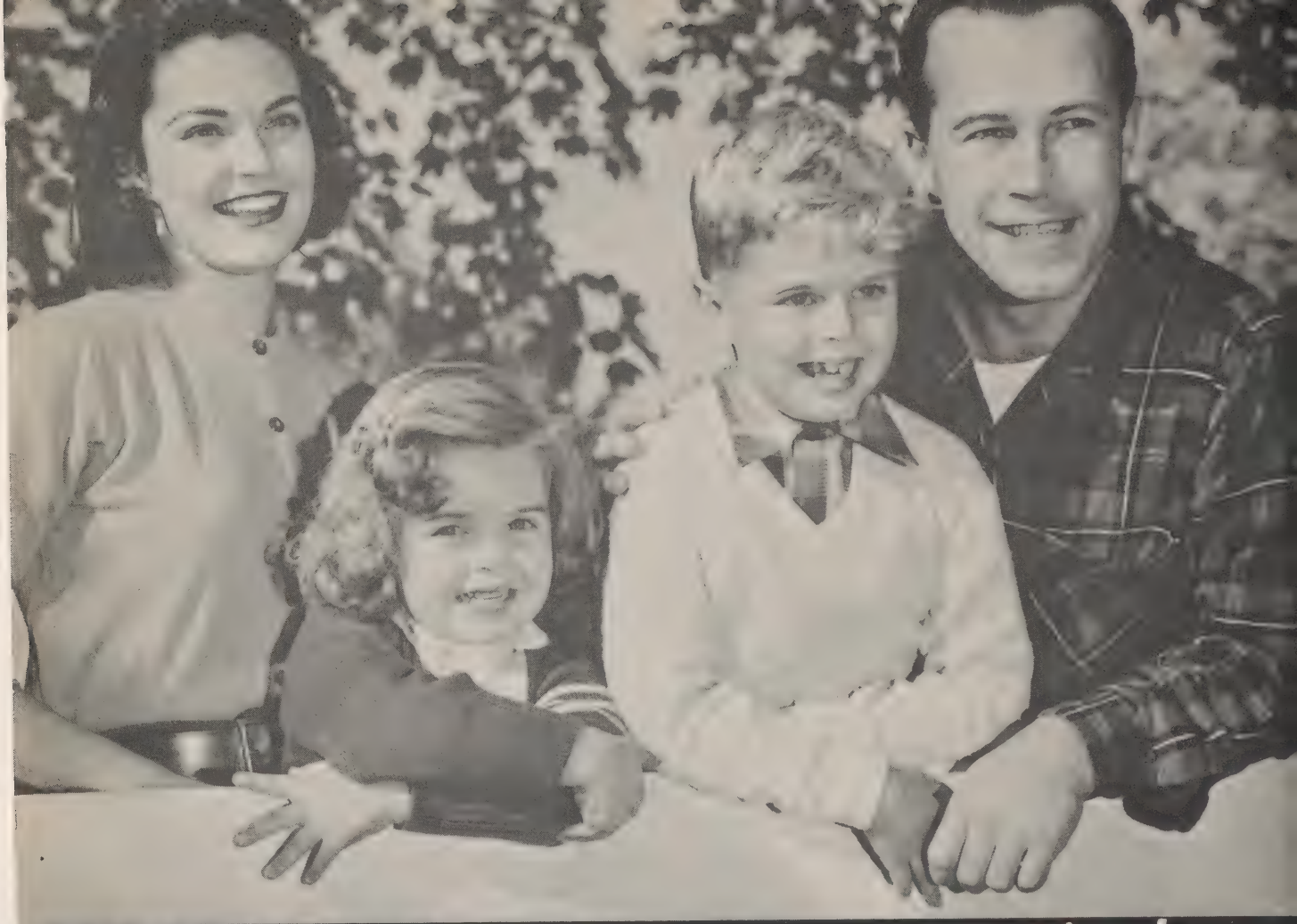
Aristocort®

Triamcinolone Lederle

SUPPLIED: Scored tablets (three strengths), syrup, parenteral and various topical forms. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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The CEVIRATE Family Plan!

CEVIRATE PEDIATRIC for the Youngsters . . .
CEVIRATE for the Adults!

When iron deficiency anemia is indicated, CEVIRATE *Tablets, which supply high level iron dosage in the form of well-tolerated ferrous fumarate, combined with ascorbic acid, provide effective therapeutic response.*

In each CEVIRATE Tablet, (coated, red) the combination of 300 mg. of ferrous fumarate (providing 99 mg. of elemental iron) with 150 mg. of ascorbic acid affords the full benefit of high level iron dosage to enhance hemoglobin response with minimum side effects.

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CEVIRATE, in the two formula concepts — is readily adaptable as a "family" prescription . . . for "individualized" treatment of iron deficiency anemia in adults or children.

SUGGESTED DOSAGE

CEVIRATE: — one tablet, two to three times daily, as directed by physician.

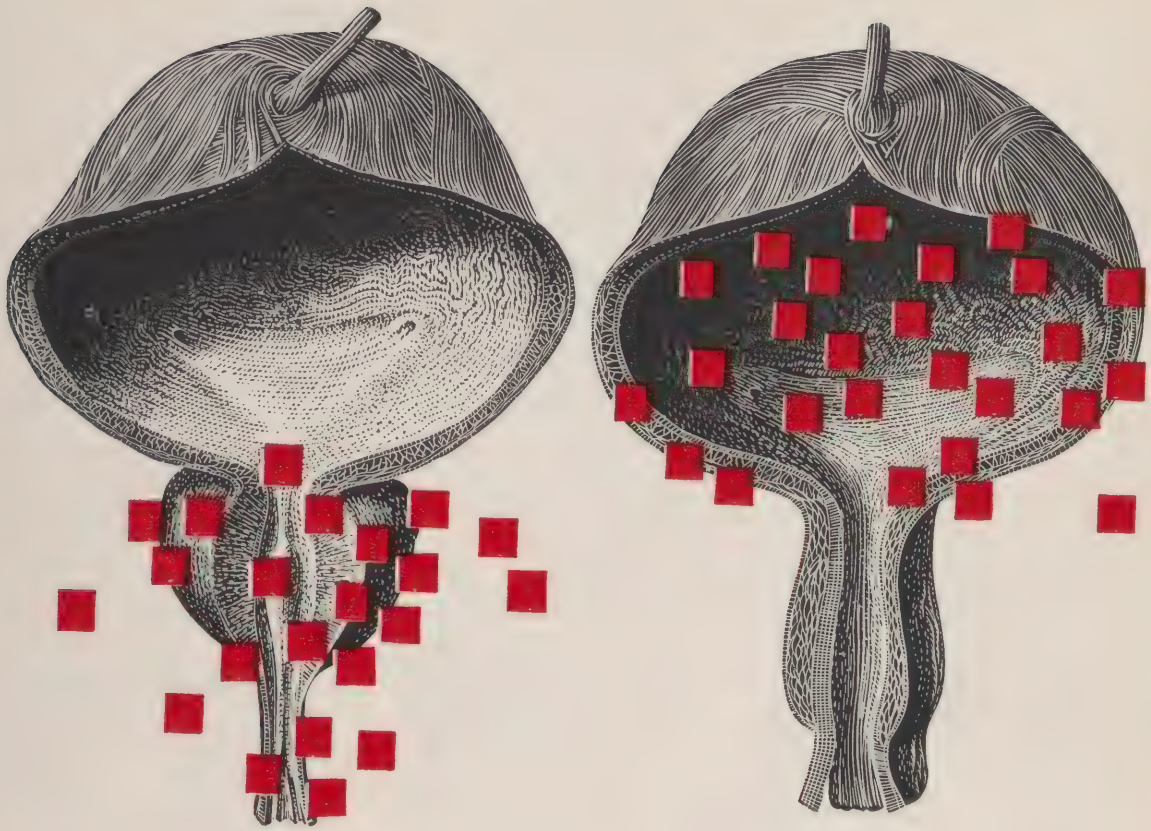
CEVIRATE PEDIATRIC: — one to three tablets daily, as directed by physician, either chewed, or dissolved in the mouth.

Supplied:

CEVIRATE — Bottles of 100, 1000, and 5000.
CEVIRATE PEDIATRIC — Bottles of 100 and 5000.

Samples and literature gladly sent upon request.

PHYSICIANS PRODUCTS CO., INC.
2022 S. SYCAMORE, PETERSBURG, VIRGINIA



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Squibb Ethoxazene (Diamino-Ethoxy-Azobenzene Hydrochloride)

Quickly eliminates pain and burning in the lower urinary tract

At real savings to your patients

Serenium provides **quick, localized analgesic action** in acute and chronic urinary tract infections with **only 1 tablet** t.i.d. Your patient is assured of the prompt action of Serenium by the harmless orange-red color of the urine; and he will feel good about the **low prescription cost,** too.

Supply: Bottles of 50 and 500 chocolate-covered tablets. Each tablet contains 0.1 Gm. of Squibb Ethoxazene. For full information see your Squibb Product Reference or Product Brief.

Serenium® is a Squibb trademark.

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NEW!

DECHOLIN-BB®

COUNTERACTS 3 COMMON CAUSES in functional G.I. disturbances related to hepatobiliary dysfunction

TENSION	SPASM	STASIS
butabarbital sodium (Warning: may be habit-forming) 15 mg. (¼ gr.)	belladonna extract 10 mg. (⅙ gr.)	dehydrocholic acid, AMES 250 mg. (3¾ gr.)

Available: Bottles of 100 tablets.

for **spasm** and **stasis**

DECHOLIN® WITH BELLADONNA

belladonna extract, 10 mg. (⅙ gr.)
dehydrocholic acid, AMES, 250 mg. (3¾ gr.)

for **stasis** alone

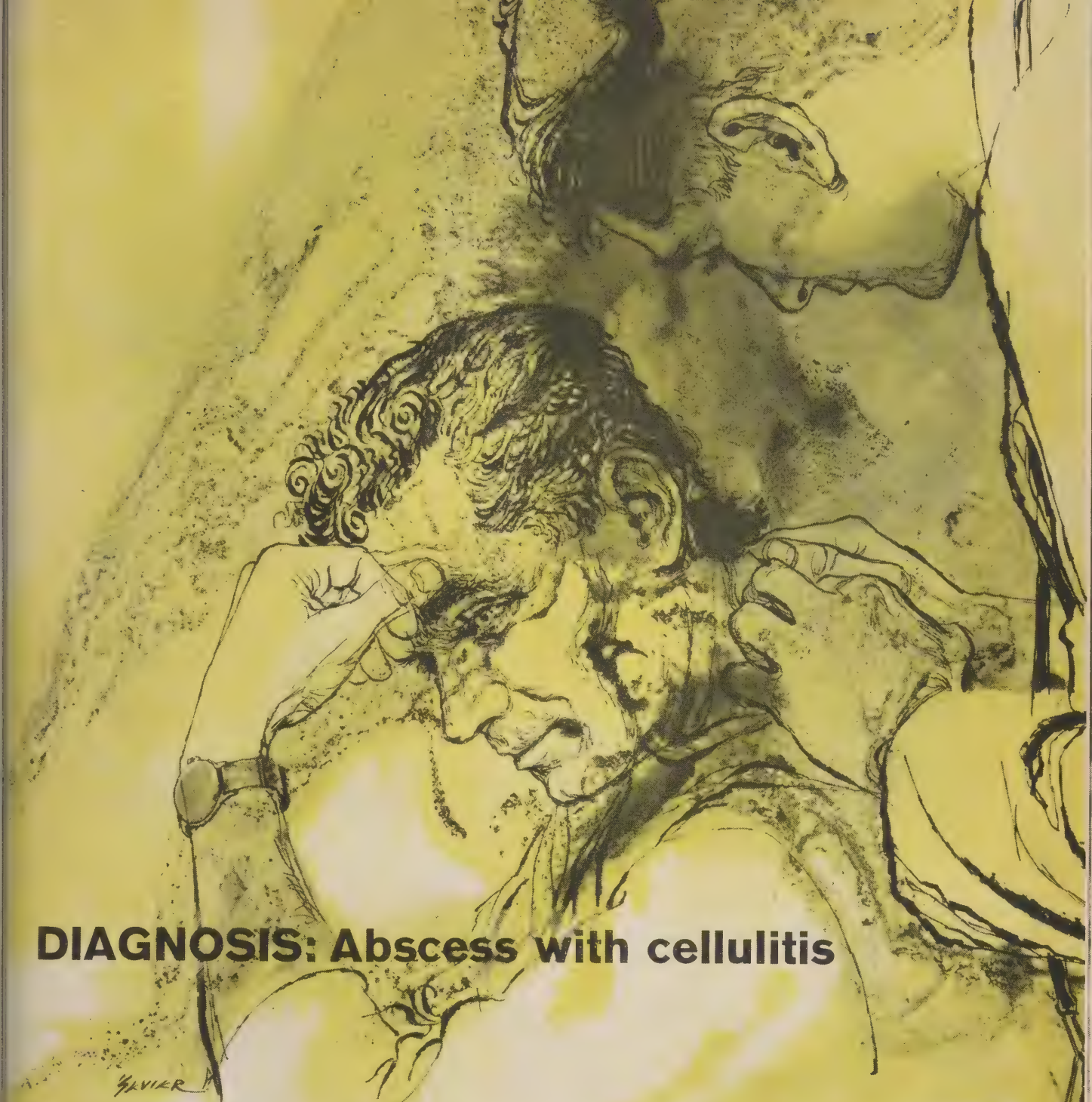
DECHOLIN®

dehydrocholic acid, AMES, 250 mg. (3¾ gr.)

Available: Bottles of 100 and 500 tablets.

Average Adult Dose—DECHOLIN-BB, DECHOLIN with Belladonna, and DECHOLIN—1 or, if necessary, 2 tablets three times daily.
Contraindications: Biliary tract obstruction, acute hepatitis, and (DECHOLIN with Belladonna and DECHOLIN-BB) glaucoma or prostatic hypertrophy. 19562

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DIAGNOSIS: Abscess with cellulitis

THERAPEUTIC NEED: Suppression of the causative organisms and drainage.

ANTIBIOTIC: DECLOMYCIN®

Demethylchlortetracycline Lederle

because it has been proved clinically effective in abscess and other soft-tissue infections.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department

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SYNergized
aspIRIN

Synirin®

Acetylsalicylic acid, 5 gr.
Pentobarbital (acid), 1/8 gr.

Simultaneous action beginning promptly
lasting four or five hours

Synirin was formulated
for a two-tablet dose for adults
and a one-tablet dose
for children from 5 to 12 years.
May be repeated every four hours
for the relief of pain

Dispensed in bottles of 100 and 1000 tablets

WM. P. POYTHRESS & CO., INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856



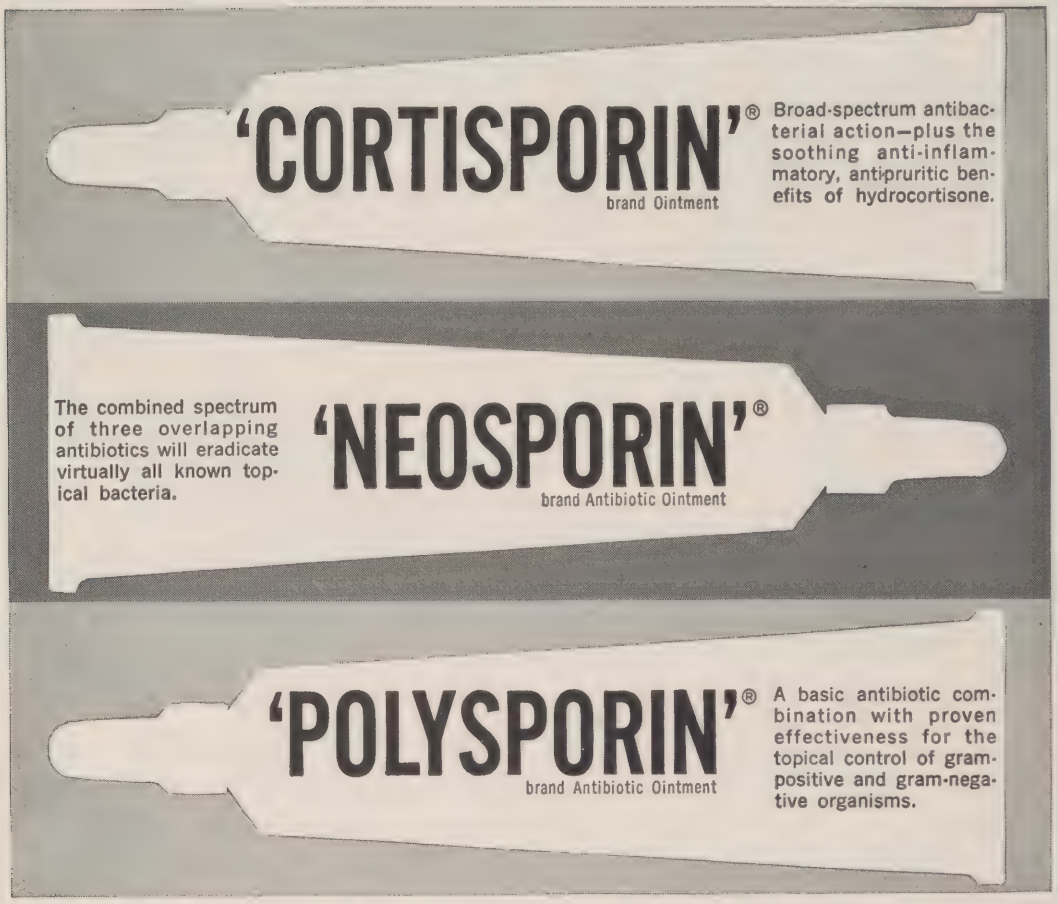
You itch . . . You scratch . . . Next thing you know, you're infected. There's a better way: THIAZINC soothes and suppresses itching, protects the skin, quickly helps heal minor infections. Cooling, flesh-colored THIAZINC contains sulfathiazole, 10%, for effective, topical bactericidal action; prepared calamine cream, 10%, for anti-pruritic and astringent effect; in a creamy-smooth water-washable base containing propylene glycol and bentonite with synergistically bacteriostatic methylparaben and propylparaben.

THIAZINC cream is indicated for pruritus and superficial infections. THIAZINC also provides soothing protection in diaper rash.

SUPPLIED: THIAZINC* (paraben-sulfathiazole-calamine cream) 1-oz. tubes, on prescription only. CAUTION: THIAZINC cream should not be used in deep cuts or wounds, or in the eyes and should be discontinued if sensitization occurs. *Trademark

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'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York



when occupational allergies strike

Dimetane® Extentabs®

CONTINUOUS 10-12 HOUR ACTION

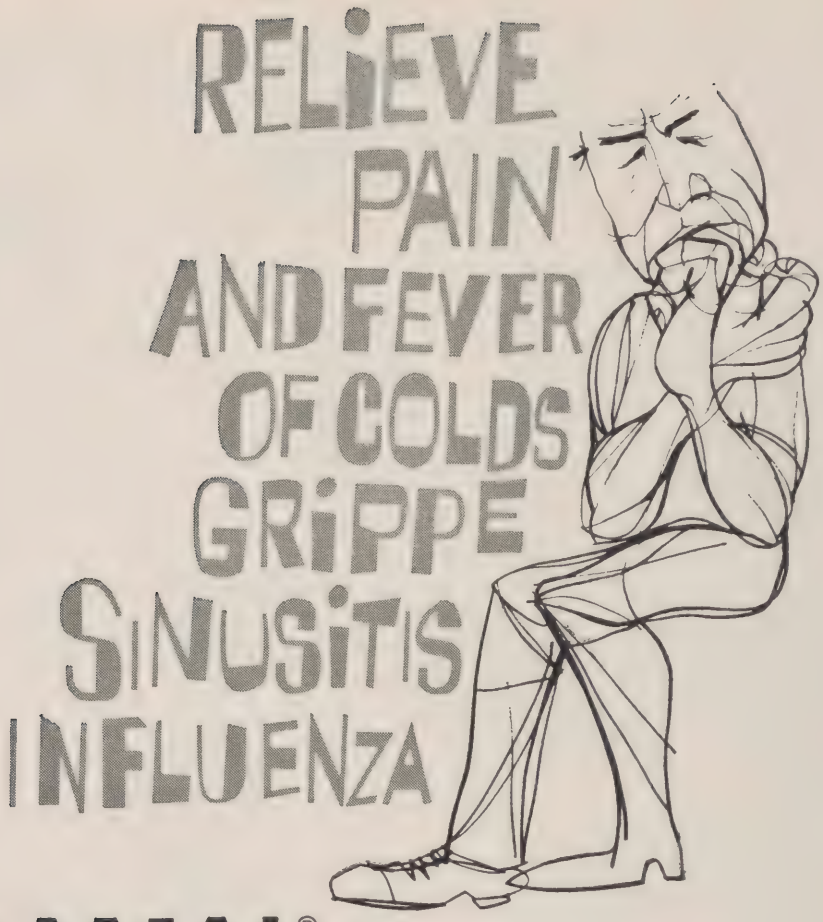
parabromdylamine (brompheniramine) maleate 12 mg.

reliably relieve the symptoms...seldom affect alertness

Beauticians (and their customers) may develop allergies to henna, dyes and oils... housewives to dust and soap... farmers to pollens and molds. Most types of allergies — occupational, seasonal or occasional reactions to foods and drugs — respond to Dimetane. With Dimetane most patients become symptom free *and* stay alert, and on the job, for Dimetane works... with a very low incidence of significant side effects. Also available in conventional tablets, 4 mg.; Elixir, 2 mg./5 cc.; Injectable, 10 mg./cc. or 100 mg./cc.

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SEEKING TOMORROW'S WITH PERSISTENCE



HASAMAL®

(Analgesic-Antipyretic-Sedative)

- **Relieves pain and tension**
- **Reduces fever**
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- **Without unwanted diaphoresis**

Hasamal, with mild sedation, effectively relieves malaise and discomfort associated with acute infectious disease, such as colds, grippe, sinusitis, tonsillitis, and for earache, headache, and pain of arthritis, neuritis, neuralgia, dysmenorrhea, etc.

Where pain of increased intensity occurs, HASACODE, containing ¼ gr. codeine phosphate, and HASACODE "STRONG," containing ½ gr. codeine phosphate, provide prompt, effective relief.

Composition: HASAMAL: Each tablet or capsule contains: Acetylsalicylic acid, 2½ gr., acetophenetidin, 2½ gr., phenobarbital, ¼ gr., and hyoscyamus alkaloids, .0337 mg. HASACODE combines the same formula as Hasamal with ¼ gr. codeine phosphate, and HASACODE "STRONG" ½ gr. codeine phosphate.

Dosage: Hasamal: One or two tablets or capsules every 3 to 4 hours. **Hasacode:** One or two tablets every 3 or 4 hours; not more than 8 tablets should be taken in 24 hours. **Warning:** Do not use in patients with glaucoma or in elderly patients with prostatic hypertrophy.

CHARLES C. HASKELL & COMPANY
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Emotional control regained...a family restored... thanks to a doctor and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

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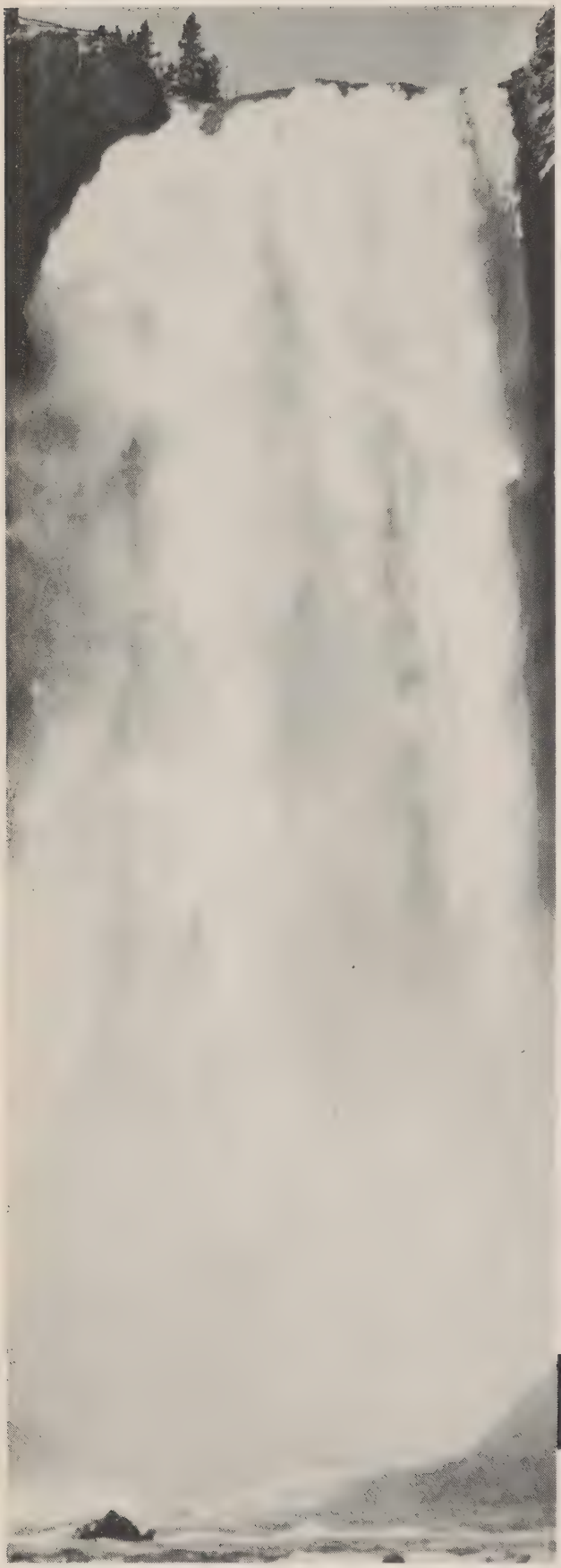
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brand of chlorpromazine

A fundamental drug
in both office and hospital practice

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PROVIDES 10 - 12 HOURS GRADUAL RELEASE . . .

Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate . . . a clinically proven dosage form. For assured 24 hour control, administer one Antora capsule before breakfast and one before evening meal. ANTORA REDUCES NITROGLYCERIN REQUIREMENTS . . . IMPROVES EKG TRACINGS . . . PROVIDES BETTER EXERCISE TOLERANCE . . . REDUCES NUMBER AND SEVERITY OF ATTACKS. Administer with caution in glaucoma.

FOR THE UNDULY APPREHENSIVE PATIENT . . .

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Timed Disintegration Capsules, containing 30 mg. Pentaerythritol Tetranitrate plus 50 mg. Secobarituric Acid. Medication is released over 10 to 12 hours with fewer side effects and less "hangover" than the longer acting barbiturates. As with Antora, capsules are administered only twice daily instead of the usual 8 to 12 tablets. Administer with caution in glaucoma.

REFER TO PDR

PAGE 643

Supplied: Bottles of 60 and 250. Literature and clinical samples available.

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for the first time...
a universal microbicidal agent that does not sensitize or retard healing

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Kills bacteria, viruses, fungi, yeasts and protozoa on contact. Non-injurious to skin, exposed tissue or mucous membranes.

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For total disability from accident:
MONTHLY BENEFIT FOR LIFE--$300.00
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MONTHLY DISABILITY AND SPECIFIC LOSS ACCIDENT BENEFITS ARE DOUBLED FOR SPECIFIED TRAVEL ACCIDENTS

$100.00 ADDITIONAL MONTHLY BENEFIT FOR TOTAL DISABILITY for as long as one year is available by rider.

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POLICY CONTINUANCE AGREEMENT for members of the South Carolina Medical Association.
Disability Benefits begin with first day of disability and medical attention.
Pays total disability income benefits for life—covering both accidents and sickness.
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OVER FIFTY

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BUILDS *body tissue...*

BUILDS *sense of well-being in the weak and debilitated*

WINSTROL®

BRAND OF STANOZOLOL

new physiotonic

NOW—the **highest** anabolic plus the **lowest** androgenic activity* with well-tolerated WINSTROL therapy

...for elderly patients with anorexia, asthenia and general debility—
MARKED IMPROVEMENT IN APPETITE, STRENGTH AND SENSE OF WELL-BEING

Fourteen patients, age 66 to 77, treated with Winstrol, usually in a dosage of 6 mg. daily, for various periods in order to correct underweight, weakness and chronic fatigue. Marked improvement occurred in appetite, sense of well-being and strength; almost all patients gained weight.

...for patients with osteoporosis and arthritis—
RELIEF OF PAIN, IMPROVEMENT IN MOBILITY

Twenty-one patients with arthritis treated with Winstrol for pain and limited mobility due to osteoporosis. With few exceptions, dosage was 6 mg. daily; duration of treatment varied from a few weeks to 6 months. In 8 patients relief of symptoms was excellent and in 6 moderate. Of the 7 persons in whom no relief was obtained, 5 had received treatment for less than one month and some had been given doses below 6 mg.

...for patients with malignant disease—
NOTABLE WEIGHT GAINS, INCREASED APPETITE AND SENSE OF WELL-BEING

Twenty-six patients, mostly women, weak, emaciated and seriously ill, were administered Winstrol in dosage of 6 mg. daily for periods extending up to 14 months (average 6.7 months). Notable weight gains occurred. Patients showed increased appetite, alertness and confidence, better appearance, increased mobility and tolerance to pain.

...for patients with chronic, non-malignant disorders—
IMPROVEMENT IN WEIGHT AND GENERAL ACTIVITY, INCREASED SENSE OF WELL-BEING

Eight patients with advanced tuberculosis, bronchopulmonary disease, nephritis and ulcerative colitis treated with 6 mg. of Winstrol daily for from 3 to 4 months. Gains in weight varied from 6 to 27 pounds with increased sense of well-being and improvement in general activity.

...for undernourished, underweight children and adolescents—
NOTABLE IMPROVEMENT IN APPETITE AND OUTLOOK, MARKED INCREASE IN WEIGHT AND HEIGHT

One hundred and twenty children, age 1 to 11 years, underweight and in poor health, were given Winstrol for several months. Majority received daily dosage of from 2 to 4 mg. In nearly all, appetite was improved. Over 70 per cent showed significant gains in weight of from 5 to 17 pounds.

DOSAGE: Usual adult dose, one 2 mg. tablet t.i.d. just before or with meals; children from 6 to 12 years, up to 1 tablet t.i.d.; children under 6 years, ½ tablet b.i.d. Available in bottles of 100 tablets.

Complete bibliography and literature available on request. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

*animal data

WITH NEW

WINSTROL

patients look better...feel stronger—because they are stronger

Winthrop LABORATORIES

New York 18, N. Y.



in alcoholism: vitamins are therapy

A full "comeback" for the alcoholic is partly dependent on nutritional balance... aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished... from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins. Supplied in decorative "reminder" jars of 30 and 100.

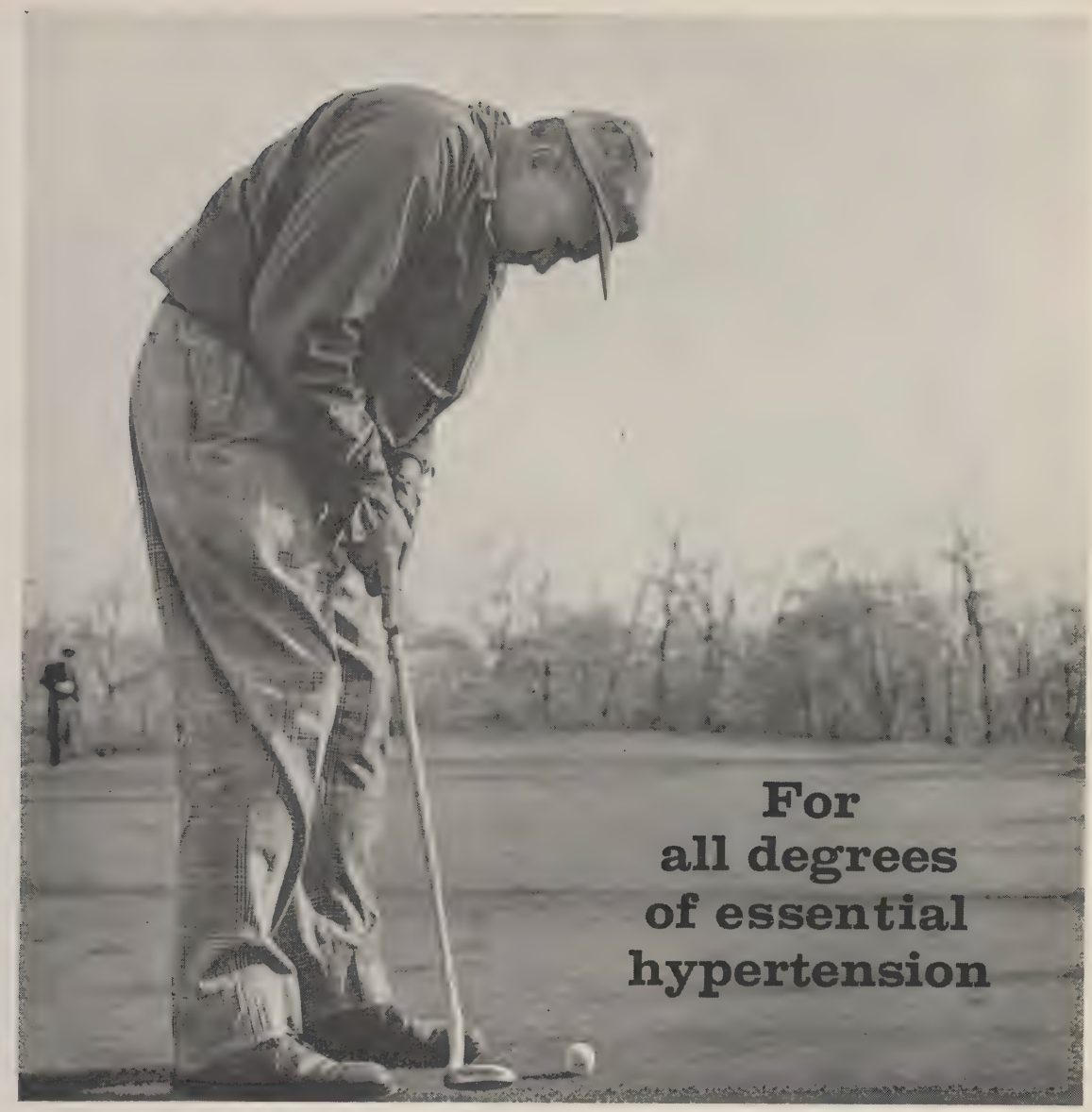
Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

Rautrax-N*

Squibb Standardized Rauwolfia Serpentina Whole Root (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

SQUIBB *Squibb Quality — the Priceless Ingredient*

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'RAUDIXIN'®, 'RAUTRAX'®, AND 'NATURETIN'® ARE SQUIBB TRADEMARKS.

"crying solitary in lonely places"



DILANTIN®

(diphenylhydantoin, Parke-Davis)

permits a richer life for the epileptic

"It has been more than twenty years since the introduction of diphenylhydantoin sodium (DILANTIN Sodium) as an anticonvulsant substance. This drug marks a milestone in the rational approach to the management of the epileptic."[1]

In grand mal and psychomotor seizures, DILANTIN is a drug of choice for a variety of reasons: • effective control of seizures[1-9] • oversedation is not a common problem[2] • possesses a wide margin of safety[3] • low incidence of side effects[3] • its use is often accompanied by improved memory, intellectual performance, and emotional stability.[10] DILANTIN (diphenylhydantoin, Parke-Davis) is available in several forms, including DILANTIN Sodium Kapseals,® 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000. Other members of the PARKE-DAVIS FAMILY OF ANTICONVULSANTS for grand mal and psychomotor seizures: PHELANTIN® Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100. for the petit mal triad: MILONTIN® Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 cc., 16-ounce bottles. CELONTIN® Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100. ZARONTIN® Capsules (ethosuximide, Parke-Davis) 0.25 Gm., bottles of 100.

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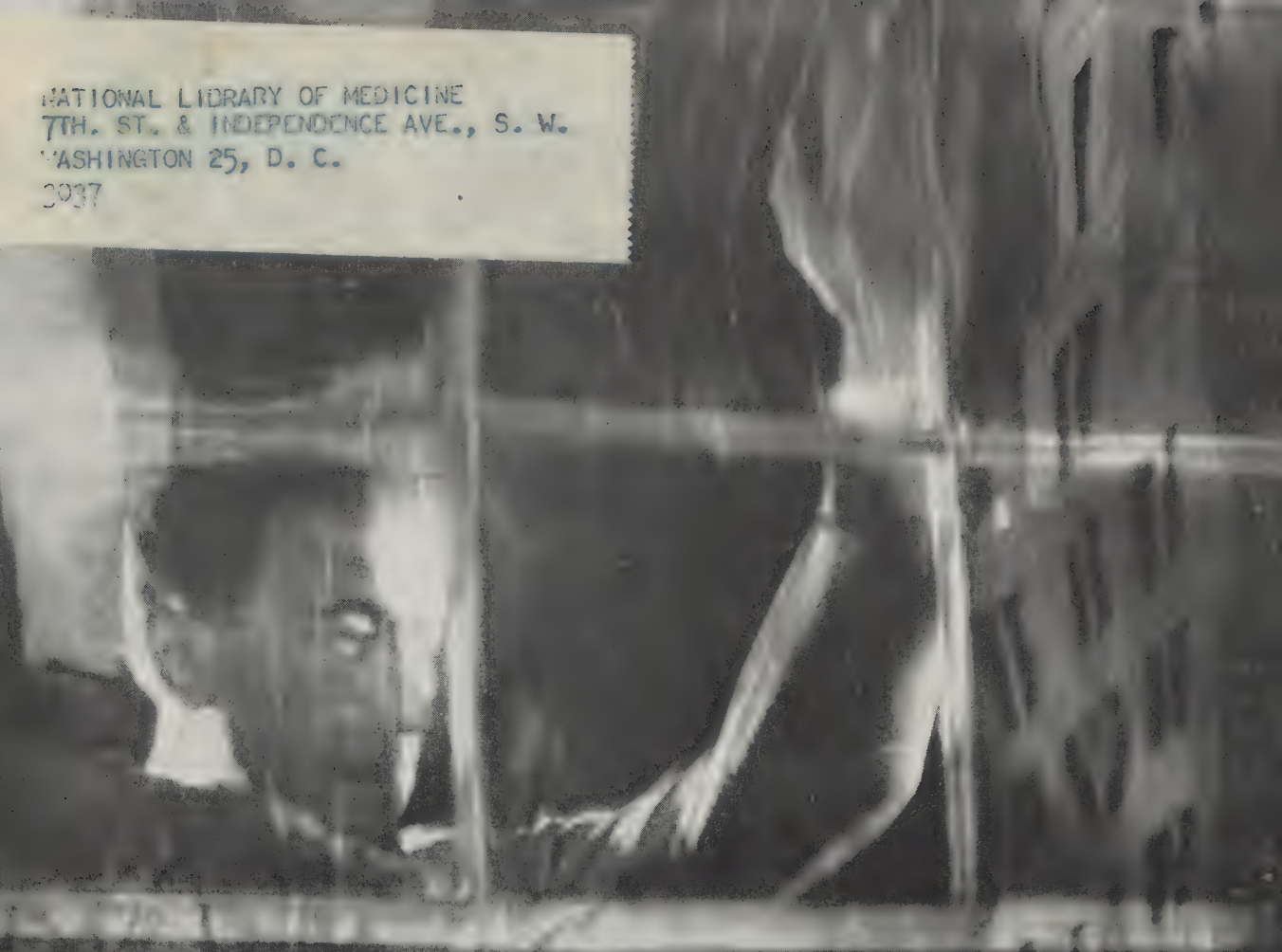
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